

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

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Editorial Revision: Common Program Requirements Background and Intent below VI.A.2.b) revised, substance use disorder language updated July 1, 2021

VI.A.2.c).(1).(b) inserted, effective July 1, 2021

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48
49 Epilepsy is a discipline within neurology that includes evaluation and treatment of
50 adults and children with seizures and seizure disorders. Specialists in epilepsy
51 possess specialized knowledge in the science, pathology, clinical evaluation,
52 diagnosis, and management of these disorders at a level beyond that expected
53 of a general or child neurologist.
54

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

56
57 The educational program in epilepsy must be 12 months in length. (Core)*
58

59 **I. Oversight**

60
61 **I.A. Sponsoring Institution**

62
63 *The Sponsoring Institution is the organization or entity that assumes the*
64 *ultimate financial and academic responsibility for a program of graduate*
65 *medical education consistent with the ACGME Institutional Requirements.*
66

67 *When the Sponsoring Institution is not a rotation site for the program, the*
68 *most commonly utilized site of clinical activity for the program is the*
69 *primary clinical site.*
70

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

71
72 **I.A.1. The program must be sponsored by one ACGME-accredited**
73 **Sponsoring Institution. (Core)**
74

75 **I.B. Participating Sites**

76
77 *A participating site is an organization providing educational experiences or*
78 *educational assignments/rotations for fellows.*
79

80 **I.B.1. The program, with approval of its Sponsoring Institution, must**
81 **designate a primary clinical site. (Core)**
82

83 **I.B.1.a)** The Sponsoring Institution must also sponsor an Accreditation
84 Council for Graduate Medical Education (ACGME)-accredited
85 residency program in child neurology or neurology. (Core)
86

87 **I.B.2. There must be a program letter of agreement (PLA) between the**
88 **program and each participating site that governs the relationship**

- 89 **between the program and the participating site providing a required**
90 **assignment.** ^(Core)
91
92 **I.B.2.a) The PLA must:**
93
94 **I.B.2.a).(1) be renewed at least every 10 years; and,** ^(Core)
95
96 **I.B.2.a).(2) be approved by the designated institutional official**
97 **(DIO).** ^(Core)
98
99 **I.B.3. The program must monitor the clinical learning and working**
100 **environment at all participating sites.** ^(Core)
101
102 **I.B.3.a) At each participating site there must be one faculty member,**
103 **designated by the program director, who is accountable for**
104 **fellow education for that site, in collaboration with the**
105 **program director.** ^(Core)
106

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**

- 107
108 **I.B.4. The program director must submit any additions or deletions of**
109 **participating sites routinely providing an educational experience,**
110 **required for all fellows, of one month full time equivalent (FTE) or**
111 **more through the ACGME's Accreditation Data System (ADS).** ^(Core)
112
113 **I.C. The program, in partnership with its Sponsoring Institution, must engage in**
114 **practices that focus on mission-driven, ongoing, systematic recruitment**
115 **and retention of a diverse and inclusive workforce of residents (if present),**
116 **fellows, faculty members, senior administrative staff members, and other**
117 **relevant members of its academic community.** ^(Core)
118

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).

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I.D. Resources

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

I.D.1.a) There must be adequate inpatient and outpatient facilities, examining areas, conference rooms, and office space for faculty members and fellows. (Core)

I.D.1.b) There must be adequate diagnostic resources, including structural and functional neuroimaging, an electroencephalography (EEG) laboratory, an Epilepsy Monitoring Unit (EMU), and an epilepsy surgery program. (Core)

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

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

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

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

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

Background and Intent: Sites must provide private and clean locations where fellows may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the fellow with the continued care of patients,

such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the fellow and the fellow's family, as outlined in VI.C.1.d).(1).

- 150
151 I.D.2.d) security and safety measures appropriate to the participating
152 site; and, ^(Core)
153
154 I.D.2.e) accommodations for fellows with disabilities consistent with
155 the Sponsoring Institution's policy. ^(Core)
156
157 I.D.3. Fellows must have ready access to subspecialty-specific and other
158 appropriate reference material in print or electronic format. This
159 must include access to electronic medical literature databases with
160 full text capabilities. ^(Core)
161
162 I.D.4. The program's educational and clinical resources must be adequate
163 to support the number of fellows appointed to the program. ^(Core)
164
165 I.D.4.a) The patient population must reflect the full spectrum of seizures
166 and epilepsy across the lifespan, including patients seen in both
167 the outpatient and inpatient settings. ^(Core)
168
169 I.E. *A fellowship program usually occurs in the context of many learners and
170 other care providers and limited clinical resources. It should be structured
171 to optimize education for all learners present.*
172
173 I.E.1. Fellows should contribute to the education of residents in core
174 programs, if present. ^(Core)
175

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.

- 176
177 II. Personnel
178
179 II.A. Program Director
180
181 II.A.1. There must be one faculty member appointed as program director
182 with authority and accountability for the overall program, including
183 compliance with all applicable program requirements. ^(Core)
184
185 II.A.1.a) The Sponsoring Institution's Graduate Medical Education
186 Committee (GMEC) must approve a change in program
187 director. ^(Core)
188
189 II.A.1.b) Final approval of the program director resides with the
190 Review Committee. ^(Core)

191

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

192

193

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

194

195

196

197

II.A.2.a) At a minimum, the program director must be provided with the salary support required to devote 10 percent FTE of non-clinical time to the administration of the program. Additional support must be provided based on program size as follows: (Core)

198

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200

201

Number of approved fellow positions	Minimum FTE
1-3	0.1
4 or more	0.15

202

Background and Intent: Ten percent FTE is defined as one half day per week.

“Administrative time” is defined as non-clinical time spent meeting the responsibilities of the program director as detailed in requirements II.A.4.-II.A.4.a).(16).

The requirement does not address the source of funding required to provide the specified salary support.

203

204

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

205

206

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

207

208

209

II.A.3.b) must include current certification in the subspecialty for which they are the program director by the American Board of Psychiatry and Neurology (ABPN) or by the American Osteopathic Board of Neurology and Psychiatry, or subspecialty qualifications that are acceptable to the Review Committee. (Core)

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II.A.3.b).(1) The Review Committee only accepts current ABPN or AOBPN certification in epilepsy. (Core)

216

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218

II.A.4. Program Director Responsibilities

219

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221

222

The program director must have responsibility, authority, and accountability for: administration and operations; teaching and

223 scholarly activity; fellow recruitment and selection, evaluation, and
224 promotion of fellows, and disciplinary action; supervision of fellows;
225 and fellow education in the context of patient care. ^(Core)

226
227 **II.A.4.a) The program director must:**

228
229 **II.A.4.a).(1) be a role model of professionalism;** ^(Core)
230

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.

231
232 **II.A.4.a).(2) design and conduct the program in a fashion**
233 **consistent with the needs of the community, the**
234 **mission(s) of the Sponsoring Institution, and the**
235 **mission(s) of the program;** ^(Core)
236

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.

237
238 **II.A.4.a).(3) administer and maintain a learning environment**
239 **conducive to educating the fellows in each of the**
240 **ACGME Competency domains;** ^(Core)
241

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.

242
243 **II.A.4.a).(4) develop and oversee a process to evaluate candidates**
244 **prior to approval as program faculty members for**
245 **participation in the fellowship program education and**
246 **at least annually thereafter, as outlined in V.B.;** ^(Core)
247

248 **II.A.4.a).(5) have the authority to approve program faculty**
249 **members for participation in the fellowship program**
250 **education at all sites;** ^(Core)
251

- 252 II.A.4.a).(6) have the authority to remove program faculty
 253 members from participation in the fellowship program
 254 education at all sites; ^(Core)
 255
 256 II.A.4.a).(7) have the authority to remove fellows from supervising
 257 interactions and/or learning environments that do not
 258 meet the standards of the program; ^(Core)
 259

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.

- 260
 261 II.A.4.a).(8) submit accurate and complete information required
 262 and requested by the DIO, GMEC, and ACGME; ^(Core)
 263
 264 II.A.4.a).(9) provide applicants who are offered an interview with
 265 information related to the applicant’s eligibility for the
 266 relevant subspecialty board examination(s); ^(Core)
 267
 268 II.A.4.a).(10) provide a learning and working environment in which
 269 fellows have the opportunity to raise concerns and
 270 provide feedback in a confidential manner as
 271 appropriate, without fear of intimidation or retaliation;
 272 ^(Core)
 273
 274 II.A.4.a).(11) ensure the program’s compliance with the Sponsoring
 275 Institution’s policies and procedures related to
 276 grievances and due process; ^(Core)
 277
 278 II.A.4.a).(12) ensure the program’s compliance with the Sponsoring
 279 Institution’s policies and procedures for due process
 280 when action is taken to suspend or dismiss, not to
 281 promote, or not to renew the appointment of a fellow;
 282 ^(Core)
 283

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.

- 284
 285 II.A.4.a).(13) ensure the program’s compliance with the Sponsoring
 286 Institution’s policies and procedures on employment
 287 and non-discrimination; ^(Core)
 288

- 289 **II.A.4.a).(13).(a)** **Fellows must not be required to sign a non-**
 290 **competition guarantee or restrictive covenant.**
 291 **(Core)**
 292
 293 **II.A.4.a).(14)** **document verification of program completion for all**
 294 **graduating fellows within 30 days; (Core)**
 295
 296 **II.A.4.a).(15)** **provide verification of an individual fellow’s**
 297 **completion upon the fellow’s request, within 30 days;**
 298 **and, (Core)**
 299

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.

- 300
 301 **II.A.4.a).(16)** **obtain review and approval of the Sponsoring**
 302 **Institution’s DIO before submitting information or**
 303 **requests to the ACGME, as required in the Institutional**
 304 **Requirements and outlined in the ACGME Program**
 305 **Director’s Guide to the Common Program**
 306 **Requirements. (Core)**
 307

308 **II.B. Faculty**

309
 310 ***Faculty members are a foundational element of graduate medical education***
 311 ***– faculty members teach fellows how to care for patients. Faculty members***
 312 ***provide an important bridge allowing fellows to grow and become practice***
 313 ***ready, ensuring that patients receive the highest quality of care. They are***
 314 ***role models for future generations of physicians by demonstrating***
 315 ***compassion, commitment to excellence in teaching and patient care,***
 316 ***professionalism, and a dedication to lifelong learning. Faculty members***
 317 ***experience the pride and joy of fostering the growth and development of***
 318 ***future colleagues. The care they provide is enhanced by the opportunity to***
 319 ***teach. By employing a scholarly approach to patient care, faculty members,***
 320 ***through the graduate medical education system, improve the health of the***
 321 ***individual and the population.***

322
 323 ***Faculty members ensure that patients receive the level of care expected***
 324 ***from a specialist in the field. They recognize and respond to the needs of***
 325 ***the patients, fellows, community, and institution. Faculty members provide***
 326 ***appropriate levels of supervision to promote patient safety. Faculty***
 327 ***members create an effective learning environment by acting in a***
 328 ***professional manner and attending to the well-being of the fellows and***
 329 ***themselves.***
 330

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

- 331
332 **II.B.1.** **For each participating site, there must be a sufficient number of**
333 **faculty members with competence to instruct and supervise all**
334 **fellows at that location.** ^(Core)
335
- 336 II.B.1.a) Faculty members must demonstrate competence in both clinical
337 care and teaching. ^(Core)
338
- 339 II.B.1.b) Faculty members or consultants with special expertise in all the
340 disciplines related to neurology, including behavioral neurology,
341 child neurology, clinical neurophysiology, epilepsy, headache,
342 movement disorders, neurocritical care, neurogenetics,
343 neuroimaging, neurology of aging, neuromuscular medicine,
344 neuro-oncology, neuro-ophthalmology, neuropathology, pain
345 management, psychiatry, sleep disorders, and vascular neurology,
346 should be available to epilepsy fellows. ^(Detail)
347
- 348 II.B.1.c) Faculty members with expertise in the performance and
349 interpretation of routine EEG, video EEG monitoring, and
350 intracranial EEG recording must be available to instruct fellows.
351 ^(Core)
352
- 353 **II.B.2. Faculty members must:**
354
- 355 **II.B.2.a) be role models of professionalism;** ^(Core)
356
- 357 **II.B.2.b) demonstrate commitment to the delivery of safe, quality,**
358 **cost-effective, patient-centered care;** ^(Core)
359
- 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.**
- 360
- 361 **II.B.2.c) demonstrate a strong interest in the education of fellows;** ^(Core)
362
- 363 **II.B.2.d) devote sufficient time to the educational program to fulfill**
364 **their supervisory and teaching responsibilities;** ^(Core)
365
- 366 **II.B.2.e) administer and maintain an educational environment**
367 **conducive to educating fellows;** ^(Core)
368
- 369 **II.B.2.f) regularly participate in organized clinical discussions,**
370 **rounds, journal clubs, and conferences; and,** ^(Core)
371
- 372 **II.B.2.g) pursue faculty development designed to enhance their skills**
373 **at least annually.** ^(Core)
374

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 Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry, 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.4. Core Faculty

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

Background and Intent: Core faculty members are critical to the success of fellow education. They support the program leadership in developing, implementing, and

assessing curriculum and in assessing fellows' progress toward achievement of competence in the subspecialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program, including completion of the annual ACGME Faculty Survey.

- 410
411 **II.B.4.a)** Core faculty members must be designated by the program
412 director. ^(Core)
413
414 **II.B.4.b)** Core faculty members must complete the annual ACGME
415 Faculty Survey. ^(Core)
416
417 **II.B.4.c)** A core faculty-to-fellow ratio of at least one to one must be
418 maintained in programs with two or more fellows. The program
419 director may be counted as one of the faculty members in
420 determining the ratio. ^(Core)
421
422 **II.B.4.d)** The program must have at least two core faculty members,
423 including the program director, who have completed education in
424 and are board certified by the ABPN in epilepsy. ^(Core)
425
426 **II.C. Program Coordinator**
427
428 **II.C.1.** There must be a program coordinator. ^(Core)
429
430 **II.C.2.** The program coordinator must be provided with support adequate
431 for administration of the program based upon its size and
432 configuration. ^(Core)
433

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 titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison with learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME.

The program coordinator is a member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management. Program coordinators are expected to develop unique knowledge of the ACGME and Program Requirements, policies, and procedures. Program coordinators assist the program director in accreditation efforts, educational programming, and support of fellows.

Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer fellows may not require a full-time coordinator; one coordinator may support more than one program.

- 434
435 **II.D. Other Program Personnel**
436

437 The program, in partnership with its Sponsoring Institution, must jointly
438 ensure the availability of necessary personnel for the effective
439 administration of the program. ^(Core)
440

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.

441
442 **III. Fellow Appointments**

443
444 **III.A. Eligibility Criteria**

445
446 **III.A.1. Eligibility Requirements – Fellowship Programs**

447
448 All required clinical education for entry into ACGME-accredited
449 fellowship programs must be completed in an ACGME-accredited
450 residency program, an AOA-approved residency program, a
451 program with ACGME International (ACGME-I) Advanced Specialty
452 Accreditation, or a Royal College of Physicians and Surgeons of
453 Canada (RCPSC)-accredited or College of Family Physicians of
454 Canada (CFPC)-accredited residency program located in Canada.
455 ^(Core)
456

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).

457
458 **III.A.1.a) Fellowship programs must receive verification of each**
459 **entering fellow’s level of competence in the required field,**
460 **upon matriculation, using ACGME, ACGME-I, or CanMEDS**
461 **Milestones evaluations from the core residency program. ^(Core)**

462
463 **III.A.1.b)** Prior to appointment in the program, fellows must have
464 successfully completed a program in neurology, child neurology,
465 or neurodevelopment disabilities that satisfies the requirements in
466 III.A.1. ^(Core)
467

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

469
470 ~~The Review Committee for Neurology will allow the following~~
471 ~~exception to the fellowship eligibility requirements:~~

472
473 **III.A.1.c).(1) ~~An ACGME-accredited fellowship program may accept~~**
474 **~~an exceptionally qualified international graduate~~**
475 **~~applicant who does not satisfy the eligibility~~**
476 **~~requirements listed in III.A.1., but who does meet all of~~**
477 **~~the following additional qualifications and conditions:~~**
478 ^(Core)
479

- 480 ~~III.A.1.c).(1).(a) ————— evaluation by the program director and~~
 481 ~~fellowship selection committee of the~~
 482 ~~applicant's suitability to enter the program,~~
 483 ~~based on prior training and review of the~~
 484 ~~summative evaluations of training in the core~~
 485 ~~specialty; and, ^(Core)~~
 486
 487 ~~III.A.1.c).(1).(b) ————— review and approval of the applicant's~~
 488 ~~exceptional qualifications by the GMEC; and,~~
 489 ~~^(Core)~~
 490
 491 ~~III.A.1.c).(1).(c) ————— verification of Educational Commission for~~
 492 ~~Foreign Medical Graduates (ECFMG)~~
 493 ~~certification. ^(Core)~~
 494
 495 ~~III.A.1.c).(2) ————— Applicants accepted through this exception must have~~
 496 ~~an evaluation of their performance by the Clinical~~
 497 ~~Competency Committee within 12 weeks of~~
 498 ~~matriculation. ^(Core)~~
 499

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.

- 500
 501 **III.B. The program director must not appoint more fellows than approved by the**
 502 **Review Committee. ^(Core)**
 503
 504 **III.B.1. All complement increases must be approved by the Review**
 505 **Committee. ^(Core)**
 506
 507 **III.C. Fellow Transfers**
 508
 509 **The program must obtain verification of previous educational experiences**
 510 **and a summative competency-based performance evaluation prior to**
 511 **acceptance of a transferring fellow, and Milestones evaluations upon**
 512 **matriculation. ^(Core)**
 513
 514 **IV. Educational Program**

515
516 ***The ACGME accreditation system is designed to encourage excellence and***
517 ***innovation in graduate medical education regardless of the organizational***
518 ***affiliation, size, or location of the program.***

519
520 ***The educational program must support the development of knowledgeable, skillful***
521 ***physicians who provide compassionate care.***

522
523 ***In addition, the program is expected to define its specific program aims consistent***
524 ***with the overall mission of its Sponsoring Institution, the needs of the community***
525 ***it serves and that its graduates will serve, and the distinctive capabilities of***
526 ***physicians it intends to graduate. While programs must demonstrate substantial***
527 ***compliance with the Common and subspecialty-specific Program Requirements, it***
528 ***is recognized that within this framework, programs may place different emphasis***
529 ***on research, leadership, public health, etc. It is expected that the program aims***
530 ***will reflect the nuanced program-specific goals for it and its graduates; for***
531 ***example, it is expected that a program aiming to prepare physician-scientists will***
532 ***have a different curriculum from one focusing on community health.***

533
534 **IV.A. The curriculum must contain the following educational components:** (Core)

535
536 **IV.A.1. a set of program aims consistent with the Sponsoring Institution’s**
537 **mission, the needs of the community it serves, and the desired**
538 **distinctive capabilities of its graduates;** (Core)

539
540 **IV.A.1.a) The program’s aims must be made available to program**
541 **applicants, fellows, and faculty members.** (Core)

542
543 **IV.A.2. competency-based goals and objectives for each educational**
544 **experience designed to promote progress on a trajectory to**
545 **autonomous practice in their subspecialty. These must be**
546 **distributed, reviewed, and available to fellows and faculty members;**
547 **(Core)**

548
549 **IV.A.3. delineation of fellow responsibilities for patient care, progressive**
550 **responsibility for patient management, and graded supervision in**
551 **their subspecialty;** (Core)

552
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.

553
554 **IV.A.4. structured educational activities beyond direct patient care; and,**
555 **(Core)**

556
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:

IV.B.1.b).(1).(a).(i) the diagnostic evaluation, medical management, and surgical evaluation of patients with epilepsy and seizures; ^(Core)

586	IV.B.1.b).(1).(a).(ii)	interviewing and examining patients with epilepsy and seizures; ^(Core)
587		
588		
589	IV.B.1.b).(1).(a).(iii)	determining the differential diagnosis of the various clinical presentations of epilepsy and seizures; ^(Core)
590		
591		
592		
593	IV.B.1.b).(1).(a).(iv)	determining the appropriate investigations for the diagnosis of epilepsy and seizures, including laboratory, pathologic, radiologic, and neurophysiologic testing; ^(Core)
594		
595		
596		
597		
598	IV.B.1.b).(1).(a).(iv).(a)	This experience must include both medical and surgical investigations. ^(Core)
599		
600		
601		
602	IV.B.1.b).(1).(a).(v)	inpatient and outpatient management of patients with epilepsy and seizures; and, ^(Core)
603		
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605		
606	IV.B.1.b).(1).(a).(v).(a)	This experience must provide management to patients being treated medically and surgically. ^(Core)
607		
608		
609		
610	IV.B.1.b).(1).(a).(vi)	working in multidisciplinary teams and coordinating patient care. ^(Core)
611		
612		
613	IV.B.1.b).(2)	Fellows must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. ^(Core)
614		
615		
616		
617	IV.B.1.c)	Medical Knowledge
618		
619		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. ^(Core)
620		
621		
622		
623		
624	IV.B.1.c).(1)	Fellows must demonstrate competence in their knowledge of:
625		
626		
627	IV.B.1.c).(1).(a)	the basic science of epilepsy and seizures; ^(Core)
628		
629	IV.B.1.c).(1).(b)	the genetics of epilepsy and seizures; ^(Core)
630		
631	IV.B.1.c).(1).(c)	the epidemiology of epilepsy and seizures; ^(Core)
632		
633	IV.B.1.c).(1).(d)	neuroimaging and other diagnostic modalities in epilepsy; ^(Core)
634		
635		
636	IV.B.1.c).(1).(e)	neuropsychology; ^(Core)

- 637
 638 IV.B.1.c).(1).(f) pharmacologic treatment of epilepsy; ^(Core)
 639
 640 IV.B.1.c).(1).(g) non-pharmacologic treatments of epilepsy; ^(Core)
 641
 642 IV.B.1.c).(1).(h) co-morbidity in epilepsy and seizures; ^(Core)
 643
 644 IV.B.1.c).(1).(i) ictal and interictal EEG patterns across the lifespan;
 645 and, ^(Core)
 646
 647 IV.B.1.c).(1).(j) prognosis in epilepsy and seizures. ^(Core)
 648

649 **IV.B.1.d)**

Practice-based Learning and Improvement

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

Background and Intent: Practice-based learning and improvement is one of the defining characteristics of being a physician. It is the ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

The intention of this Competency is to help a fellow refine the habits of mind required to continuously pursue quality improvement, well past the completion of fellowship.

- 656
 657 **IV.B.1.e)** **Interpersonal and Communication Skills**
 658
 659 **Fellows must demonstrate interpersonal and communication**
 660 **skills that result in the effective exchange of information and**
 661 **collaboration with patients, their families, and health**
 662 **professionals. ^(Core)**
 663

664 **IV.B.1.f)**

Systems-based Practice

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

672 **IV.C.**

Curriculum Organization and Fellow Experiences

674 **IV.C.1.**

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

678 **IV.C.1.a)**

Assignment of rotations must be structured to minimize the frequency of rotational transitions and rotations must be of

680 sufficient length to provide a quality educational experience,
681 defined by continuity of patient care, ongoing supervision,
682 longitudinal relationships with faculty members, and high-quality
683 assessment and feedback. ^(Core)
684

685 IV.C.1.b) Clinical experiences must be structured to facilitate learning in a
686 manner that allows the fellows to function as part of an effective
687 health care team that works together longitudinally with shared
688 goals of patient safety and quality improvement. ^(Core)
689

690 **IV.C.2. The program must provide instruction and experience in pain**
691 **management if applicable for the subspecialty, including recognition**
692 **of the signs of addiction.** ^(Core)
693

694 IV.C.3. The program director must, with assistance from faculty members,
695 develop and implement the academic and clinical educational program
696 by: ^(Core)
697

698 IV.C.3.a) preparing and implementing a comprehensive, well organized,
699 and effective curriculum, both academic and clinical, which
700 includes the presentation of core specialty knowledge
701 supplemented by the addition of current information; and, ^(Core)
702

703 IV.C.3.b) providing fellows with direct experience in progressive
704 responsibility for patient management. ^(Core)
705

706 IV.C.4. The curriculum must include the equivalent of at least six months of full-
707 time patient care in inpatient and outpatient epilepsy. ^(Core)
708

709 IV.C.4.a) Time spent in the EMU may be counted toward the six-month
710 minimum if a fellow's clinical experience involves patient
711 management. ^(Detail)
712

713 IV.C.4.b) This must include a minimum of three months of EEG and video-
714 EEG monitoring, and must include: ^(Core)
715

716 IV.C.4.b).(1) routine EEGs: 50 as the primary reviewer, including
717 responsibility for the main writing of the report; ^(Core)
718

719 IV.C.4.b).(2) Phase 1 scalp monitoring (prolonged, overnight studies):
720 20 as the primary reviewer, including responsibility for the
721 report; and, ^(Core)
722

723 IV.C.4.b).(3) Phase 2 intracranial monitoring, including subdural grid,
724 depth, and intra-operative electrocorticograph recordings:
725 five as the primary reviewer, including responsibility for the
726 report. ^(Core)
727

728 IV.C.4.b).(4) A minimum of one month of elective time must be
729 provided. ^(Core)
730

- 731 IV.C.4.b).(5) The remaining time should include additional experience in
732 the care of patients with epilepsy and seizures, or epilepsy
733 research, or neuropsychology, or psychiatry, or
734 neuroimaging. ^(Detail)
735
- 736 IV.C.5. Programs may be primarily child or adult epilepsy programs, but fellows
737 must have experience in the care of both adults and children. ^(Core)
738
- 739 IV.C.5.a) A program that is primarily adult-based must include a minimum of
740 one month of clinical exposure to the care of children with epilepsy
741 and seizures. ^(Core)
742
- 743 IV.C.5.b) A program that is primarily child-based must include a minimum of
744 one month of clinical exposure to the care of adults with epilepsy
745 and seizures. ^(Core)
746
- 747 IV.C.6. Fellows must attend required seminars, conferences, and journal clubs.
748 ^(Core)
749
- 750 IV.C.7. Seminars and conferences must include the full spectrum of epilepsy and
751 seizures across the lifespan. ^(Core)
752
- 753 **IV.D. Scholarship**
754
- 755 ***Medicine is both an art and a science. The physician is a humanistic***
756 ***scientist who cares for patients. This requires the ability to think critically,***
757 ***evaluate the literature, appropriately assimilate new knowledge, and***
758 ***practice lifelong learning. The program and faculty must create an***
759 ***environment that fosters the acquisition of such skills through fellow***
760 ***participation in scholarly activities as defined in the subspecialty-specific***
761 ***Program Requirements. Scholarly activities may include discovery,***
762 ***integration, application, and teaching.***
763
- 764 ***The ACGME recognizes the diversity of fellowships and anticipates that***
765 ***programs prepare physicians for a variety of roles, including clinicians,***
766 ***scientists, and educators. It is expected that the program’s scholarship will***
767 ***reflect its mission(s) and aims, and the needs of the community it serves.***
768 ***For example, some programs may concentrate their scholarly activity on***
769 ***quality improvement, population health, and/or teaching, while other***
770 ***programs might choose to utilize more classic forms of biomedical***
771 ***research as the focus for scholarship.***
772
- 773 **IV.D.1. Program Responsibilities**
774
- 775 **IV.D.1.a) The program must demonstrate evidence of scholarly**
776 **activities, consistent with its mission(s) and aims. ^(Core)**
777
- 778 **IV.D.1.b) The program in partnership with its Sponsoring Institution,**
779 **must allocate adequate resources to facilitate fellow and**
780 **faculty involvement in scholarly activities. ^(Core)**
781

782 **IV.D.2. Faculty Scholarly Activity**

783
784 **IV.D.2.a) Among their scholarly activity, programs must demonstrate**
785 **accomplishments in at least three of the following domains:**
786 **(Core)**

- 787
788
- 789 • **Research in basic science, education, translational**
 - 790 **science, patient care, or population health**
 - 791 • **Peer-reviewed grants**
 - 792 • **Quality improvement and/or patient safety initiatives**
 - 793 • **Systematic reviews, meta-analyses, review articles,**
 - 794 **chapters in medical textbooks, or case reports**
 - 795 • **Creation of curricula, evaluation tools, didactic**
 - 796 **educational activities, or electronic educational**
 - 797 **materials**
 - 798 • **Contribution to professional committees, educational**
 - 799 **organizations, or editorial boards**
 - 800 • **Innovations in education**

801 **IV.D.2.b) The program must demonstrate dissemination of scholarly**
802 **activity within and external to the program by the following**
803 **methods:**
804

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.

805
806 **IV.D.2.b).(1) faculty participation in grand rounds, posters,**
807 **workshops, quality improvement presentations,**
808 **podium presentations, grant leadership, non-peer-**
809 **reviewed print/electronic resources, articles or**
810 **publications, book chapters, textbooks, webinars,**
811 **service on professional committees, or serving as a**
812 **journal reviewer, journal editorial board member, or**
813 **editor; (Outcome)‡**

814
815 **IV.D.2.b).(2) peer-reviewed publication. (Outcome)**
816

817 **IV.D.3. Fellow Scholarly Activity**

818
819 **IV.D.3.a) The curriculum must advance fellows’ knowledge of the basic**
820 **principles of evidence-based medicine and research, including**
821 **how research is conducted, evaluated, explained to patients, and**
822 **applied to patient care. (Core)**

- 823
824 IV.D.3.b) Fellows should participate in scholarly activity under the
825 mentorship of program faculty members. ^(Detail)
826
827 IV.D.3.c) The Sponsoring Institution and program should allocate adequate
828 educational resources to facilitate fellow involvement in scholarly
829 activities. ^(Detail)
830
831 IV.D.3.d) Fellows should receive support to attend one regional, national, or
832 international professional conference during the program. ^(Detail)
833

834 **V. Evaluation**

835
836 **V.A. Fellow Evaluation**

837
838 **V.A.1. Feedback and Evaluation**
839

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.

- 840
841 **V.A.1.a) Faculty members must directly observe, evaluate, and**
842 **frequently provide feedback on fellow performance during**
843 **each rotation or similar educational assignment. ^(Core)**
844

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.

- 845
846 **V.A.1.b)** Evaluation must be documented at the completion of the
847 assignment. ^(Core)
848
849 **V.A.1.b).(1)** For block rotations of greater than three months in
850 duration, evaluation must be documented at least
851 every three months. ^(Core)
852
853 **V.A.1.b).(2)** Longitudinal experiences such as continuity clinic in
854 the context of other clinical responsibilities must be
855 evaluated at least every three months and at
856 completion. ^(Core)
857
858 **V.A.1.c)** The program must provide an objective performance
859 evaluation based on the Competencies and the subspecialty-
860 specific Milestones, and must: ^(Core)
861
862 **V.A.1.c).(1)** use multiple evaluators (e.g., faculty members, peers,
863 patients, self, and other professional staff members);
864 and, ^(Core)
865
866 **V.A.1.c).(2)** provide that information to the Clinical Competency
867 Committee for its synthesis of progressive fellow
868 performance and improvement toward unsupervised
869 practice. ^(Core)
870

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.

- 871
872 **V.A.1.d)** The program director or their designee, with input from the
873 Clinical Competency Committee, must:
874
875 **V.A.1.d).(1)** meet with and review with each fellow their
876 documented semi-annual evaluation of performance,
877 including progress along the subspecialty-specific
878 Milestones. ^(Core)
879

880 V.A.1.d).(2) assist fellows in developing individualized learning
881 plans to capitalize on their strengths and identify areas
882 for growth; and, (Core)

883
884 V.A.1.d).(3) develop plans for fellows failing to progress, following
885 institutional policies and procedures. (Core)
886

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.

887
888 V.A.1.e) At least annually, there must be a summative evaluation of
889 each fellow that includes their readiness to progress to the
890 next year of the program, if applicable. (Core)

891
892 V.A.1.f) The evaluations of a fellow's performance must be accessible
893 for review by the fellow. (Core)
894

895 V.A.2. Final Evaluation

896
897 V.A.2.a) The program director must provide a final evaluation for each
898 fellow upon completion of the program. (Core)
899

900 V.A.2.a).(1) The subspecialty-specific Milestones, and when
901 applicable the subspecialty-specific Case Logs, must
902 be used as tools to ensure fellows are able to engage
903 in autonomous practice upon completion of the
904 program. (Core)

905
906 V.A.2.a).(2) The final evaluation must:

907
908 V.A.2.a).(2).(a) become part of the fellow's permanent record
909 maintained by the institution, and must be
910 accessible for review by the fellow in
911 accordance with institutional policy; (Core)
912

- 913 V.A.2.a).(2).(b) verify that the fellow has demonstrated the
 914 knowledge, skills, and behaviors necessary to
 915 enter autonomous practice; ^(Core)
 916
- 917 V.A.2.a).(2).(c) consider recommendations from the Clinical
 918 Competency Committee; and, ^(Core)
 919
- 920 V.A.2.a).(2).(d) be shared with the fellow upon completion of
 921 the program. ^(Core)
 922
- 923 V.A.3. A Clinical Competency Committee must be appointed by the
 924 program director. ^(Core)
 925
- 926 V.A.3.a) At a minimum the Clinical Competency Committee must
 927 include three members, at least one of whom is a core faculty
 928 member. Members must be faculty members from the same
 929 program or other programs, or other health professionals
 930 who have extensive contact and experience with the
 931 program's fellows. ^(Core)
 932
- 933 V.A.3.b) The Clinical Competency Committee must:
- 934
- 935 V.A.3.b).(1) review all fellow evaluations at least semi-annually;
 936 ^(Core)
 937
- 938 V.A.3.b).(2) determine each fellow's progress on achievement of
 939 the subspecialty-specific Milestones; and, ^(Core)
 940
- 941 V.A.3.b).(3) meet prior to the fellows' semi-annual evaluations and
 942 advise the program director regarding each fellow's
 943 progress. ^(Core)
 944
- 945 V.B. Faculty Evaluation
- 946
- 947 V.B.1. The program must have a process to evaluate each faculty
 948 member's performance as it relates to the educational program at
 949 least annually. ^(Core)
 950

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.

- 951
952 **V.B.1.a)** This evaluation must include a review of the faculty member's
953 clinical teaching abilities, engagement with the educational
954 program, participation in faculty development related to their
955 skills as an educator, clinical performance, professionalism,
956 and scholarly activities. (Core)
957
958 **V.B.1.b)** This evaluation must include written, confidential evaluations
959 by the fellows. (Core)
960
961 **V.B.2.** Faculty members must receive feedback on their evaluations at least
962 annually. (Core)
963
964 **V.B.3.** Results of the faculty educational evaluations should be
965 incorporated into program-wide faculty development plans. (Core)
966

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.

- 967
968 **V.C. Program Evaluation and Improvement**
969
970 **V.C.1.** The program director must appoint the Program Evaluation
971 Committee to conduct and document the Annual Program
972 Evaluation as part of the program's continuous improvement
973 process. (Core)
974
975 **V.C.1.a)** The Program Evaluation Committee must be composed of at
976 least two program faculty members, at least one of whom is a
977 core faculty member, and at least one fellow. (Core)
978
979 **V.C.1.b)** Program Evaluation Committee responsibilities must include:
980
981 **V.C.1.b).(1)** acting as an advisor to the program director, through
982 program oversight; (Core)
983
984 **V.C.1.b).(2)** review of the program's self-determined goals and
985 progress toward meeting them; (Core)
986
987 **V.C.1.b).(3)** guiding ongoing program improvement, including
988 development of new goals, based upon outcomes;
989 and, (Core)

990
991 **V.C.1.b).(4)** review of the current operating environment to identify
992 strengths, challenges, opportunities, and threats as
993 related to the program’s mission and aims. ^(Core)
994

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.

995
996 **V.C.1.c)** The Program Evaluation Committee should consider the
997 following elements in its assessment of the program:
998
999 **V.C.1.c).(1)** curriculum; ^(Core)
1000
1001 **V.C.1.c).(2)** outcomes from prior Annual Program Evaluation(s);
1002 ^(Core)
1003
1004 **V.C.1.c).(3)** ACGME letters of notification, including citations,
1005 Areas for Improvement, and comments; ^(Core)
1006
1007 **V.C.1.c).(4)** quality and safety of patient care; ^(Core)
1008
1009 **V.C.1.c).(5)** aggregate fellow and faculty:
1010
1011 **V.C.1.c).(5).(a)** well-being; ^(Core)
1012
1013 **V.C.1.c).(5).(b)** recruitment and retention; ^(Core)
1014
1015 **V.C.1.c).(5).(c)** workforce diversity; ^(Core)
1016
1017 **V.C.1.c).(5).(d)** engagement in quality improvement and patient
1018 safety; ^(Core)
1019
1020 **V.C.1.c).(5).(e)** scholarly activity; ^(Core)
1021
1022 **V.C.1.c).(5).(f)** ACGME Resident/Fellow and Faculty Surveys
1023 (where applicable); and, ^(Core)
1024
1025 **V.C.1.c).(5).(g)** written evaluations of the program. ^(Core)
1026
1027 **V.C.1.c).(6)** aggregate fellow:
1028
1029 **V.C.1.c).(6).(a)** achievement of the Milestones; ^(Core)
1030
1031 **V.C.1.c).(6).(b)** in-training examinations (where applicable);
1032 ^(Core)
1033
1034 **V.C.1.c).(6).(c)** board pass and certification rates; and, ^(Core)

- 1035
- 1036 **V.C.1.c).(6).(d)** graduate performance. ^(Core)
- 1037
- 1038 **V.C.1.c).(7)** aggregate faculty:
- 1039
- 1040 **V.C.1.c).(7).(a)** evaluation; and, ^(Core)
- 1041
- 1042 **V.C.1.c).(7).(b)** professional development ^(Core)
- 1043
- 1044 **V.C.1.d)** The Program Evaluation Committee must evaluate the
- 1045 program's mission and aims, strengths, areas for
- 1046 improvement, and threats. ^(Core)
- 1047
- 1048 **V.C.1.e)** The annual review, including the action plan, must:
- 1049
- 1050 **V.C.1.e).(1)** be distributed to and discussed with the members of
- 1051 the teaching faculty and the fellows; and, ^(Core)
- 1052
- 1053 **V.C.1.e).(2)** be submitted to the DIO. ^(Core)
- 1054
- 1055 **V.C.2.** The program must participate in a Self-Study prior to its 10-Year
- 1056 Accreditation Site Visit. ^(Core)
- 1057
- 1058 **V.C.2.a)** A summary of the Self-Study must be submitted to the DIO.
- 1059 ^(Core)
- 1060

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.

- 1061
- 1062 **V.C.3.** *One goal of ACGME-accredited education is to educate physicians*
- 1063 *who seek and achieve board certification. One measure of the*
- 1064 *effectiveness of the educational program is the ultimate pass rate.*
- 1065
- 1066 *The program director should encourage all eligible program*
- 1067 *graduates to take the certifying examination offered by the*
- 1068 *applicable American Board of Medical Specialties (ABMS) member*
- 1069 *board or American Osteopathic Association (AOA) certifying board.*
- 1070
- 1071 **V.C.3.a)** For subspecialties in which the ABMS member board and/or
- 1072 AOA certifying board offer(s) an annual written exam, in the
- 1073 preceding three years, the program's aggregate pass rate of
- 1074 those taking the examination for the first time must be higher

- 1075 than the bottom fifth percentile of programs in that
 1076 subspecialty. ^{(Outcome)‡}
 1077
- 1078 **V.C.3.b)** For subspecialties in which the ABMS member board and/or
 1079 AOA certifying board offer(s) a biennial written exam, in the
 1080 preceding six years, the program’s aggregate pass rate of
 1081 those taking the examination for the first time must be higher
 1082 than the bottom fifth percentile of programs in that
 1083 subspecialty. ^(Outcome)
 1084
- 1085 **V.C.3.c)** For subspecialties in which the ABMS member board and/or
 1086 AOA certifying board offer(s) an annual oral exam, in the
 1087 preceding three years, the program’s aggregate pass rate of
 1088 those taking the examination for the first time must be higher
 1089 than the bottom fifth percentile of programs in that
 1090 subspecialty. ^(Outcome)
 1091
- 1092 **V.C.3.d)** For subspecialties in which the ABMS member board and/or
 1093 AOA certifying board offer(s) a biennial oral exam, in the
 1094 preceding six years, the program’s aggregate pass rate of
 1095 those taking the examination for the first time must be higher
 1096 than the bottom fifth percentile of programs in that
 1097 subspecialty. ^(Outcome)
 1098
- 1099 **V.C.3.e)** For each of the exams referenced in V.C.3.a)-d), any program
 1100 whose graduates over the time period specified in the
 1101 requirement have achieved an 80 percent pass rate will have
 1102 met this requirement, no matter the percentile rank of the
 1103 program for pass rate in that subspecialty. ^(Outcome)
 1104

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.

- 1105
 1106 **V.C.3.f)** Programs must report, in ADS, board certification status
 1107 annually for the cohort of board-eligible fellows that
 1108 graduated seven years earlier. ^(Core)
 1109

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**
- A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.*
- VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.**
(Core)
- VI.A.1.a).(1).(b) The program must have a structure that promotes safe, interprofessional, team-based care.**
(Core)
- VI.A.1.a).(2) Education on Patient Safety**

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

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

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

Patient Safety Events

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

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

Residents, fellows, faculty members, and other clinical staff members must:

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

know their responsibilities in reporting patient safety events at the clinical site; ^(Core)

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

know how to report patient safety events, including near misses, at the clinical site; and, ^(Core)

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

be provided with summary information of their institution’s patient safety reports. ^(Core)

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

Fellows must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. ^(Core)

VI.A.1.a).(4)

Fellow Education and Experience in Disclosure of Adverse Events

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

1227	VI.A.1.a).(4).(a)	All fellows must receive training in how to disclose adverse events to patients and families. ^(Core)
1228		
1229		
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1231	VI.A.1.a).(4).(b)	Fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated. ^(Detail)
1232		
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1234		
1235	VI.A.1.b)	Quality Improvement
1236		
1237	VI.A.1.b).(1)	Education in Quality Improvement
1238		
1239		<i>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.</i>
1240		
1241		
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1243		
1244	VI.A.1.b).(1).(a)	Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities. ^(Core)
1245		
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1248	VI.A.1.b).(2)	Quality Metrics
1249		
1250		<i>Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.</i>
1251		
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1253		
1254	VI.A.1.b).(2).(a)	Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. ^(Core)
1255		
1256		
1257		
1258	VI.A.1.b).(3)	Engagement in Quality Improvement Activities
1259		
1260		<i>Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.</i>
1261		
1262		
1263		
1264	VI.A.1.b).(3).(a)	Fellows must have the opportunity to participate in interprofessional quality improvement activities. ^(Core)
1265		
1266		
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1268	VI.A.1.b).(3).(a).(i)	This should include activities aimed at reducing health care disparities. ^(Detail)
1269		
1270		
1271	VI.A.2.	Supervision and Accountability
1272		
1273	VI.A.2.a)	<i>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,</i>
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1278 *and monitor a structured chain of responsibility and*
1279 *accountability as it relates to the supervision of all patient*
1280 *care.*

1281
1282 *Supervision in the setting of graduate medical education*
1283 *provides safe and effective care to patients; ensures each*
1284 *fellow's development of the skills, knowledge, and attitudes*
1285 *required to enter the unsupervised practice of medicine; and*
1286 *establishes a foundation for continued professional growth.*

1287
1288 **VI.A.2.a).(1)** Each patient must have an identifiable and
1289 appropriately-credentialed and privileged attending
1290 physician (or licensed independent practitioner as
1291 specified by the applicable Review Committee) who is
1292 responsible and accountable for the patient's care.
1293 (Core)

1294
1295 **VI.A.2.a).(1).(a)** This information must be available to fellows,
1296 faculty members, other members of the health
1297 care team, and patients. (Core)

1298
1299 **VI.A.2.a).(1).(b)** Fellows and faculty members must inform each
1300 patient of their respective roles in that patient's
1301 care when providing direct patient care. (Core)

1302
1303 **VI.A.2.b)** *Supervision may be exercised through a variety of methods.*
1304 *For many aspects of patient care, the supervising physician*
1305 *may be a more advanced fellow. Other portions of care*
1306 *provided by the fellow can be adequately supervised by the*
1307 *appropriate availability of the supervising faculty member or*
1308 *fellow, either on site or by means of telecommunication*
1309 *technology. Some activities require the physical presence of*
1310 *the supervising faculty member. In some circumstances,*
1311 *supervision may include post-hoc review of fellow-delivered*
1312 *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.

1314
1315 **VI.A.2.b).(1)** The program must demonstrate that the appropriate
1316 level of supervision in place for all fellows is based on
1317 each fellow's level of training and ability, as well as
1318 patient complexity and acuity. Supervision may be

1319		exercised through a variety of methods, as appropriate
1320		to the situation. ^(Core)
1321		
1322	VI.A.2.b).(2)	The program must define when physical presence of a
1323		supervising physician is required. ^(Core)
1324		
1325	VI.A.2.c)	Levels of Supervision
1326		
1327		To promote appropriate fellow supervision while providing
1328		for graded authority and responsibility, the program must use
1329		the following classification of supervision: ^(Core)
1330		
1331	VI.A.2.c).(1)	Direct Supervision:
1332		
1333	VI.A.2.c).(1).(a)	the supervising physician is physically present
1334		with the fellow during the key portions of the
1335		patient interaction; or, ^(Core)
1336		
1337	VI.A.2.c).(1).(b)	the supervising physician and/or patient is not
1338		physically present with the fellow and the
1339		supervising physician is concurrently
1340		monitoring the patient care through appropriate
1341		telecommunication technology. ^(Core)
1342		
1343	VI.A.2.c).(2)	Indirect Supervision: the supervising physician is not
1344		providing physical or concurrent visual or audio
1345		supervision but is immediately available to the fellow
1346		for guidance and is available to provide appropriate
1347		direct supervision. ^(Core)
1348		
1349	VI.A.2.c).(3)	Oversight – the supervising physician is available to
1350		provide review of procedures/encounters with
1351		feedback provided after care is delivered. ^(Core)
1352		
1353	VI.A.2.d)	The privilege of progressive authority and responsibility,
1354		conditional independence, and a supervisory role in patient
1355		care delegated to each fellow must be assigned by the
1356		program director and faculty members. ^(Core)
1357		
1358	VI.A.2.d).(1)	The program director must evaluate each fellow’s
1359		abilities based on specific criteria, guided by the
1360		Milestones. ^(Core)
1361		
1362	VI.A.2.d).(2)	Faculty members functioning as supervising
1363		physicians must delegate portions of care to fellows
1364		based on the needs of the patient and the skills of
1365		each fellow. ^(Core)
1366		
1367	VI.A.2.d).(3)	Fellows should serve in a supervisory role to junior
1368		fellows and residents in recognition of their progress
1369		toward independence, based on the needs of each

1370 patient and the skills of the individual resident or
1371 fellow. ^(Detail)

1372
1373 **VI.A.2.e)** Programs must set guidelines for circumstances and events
1374 in which fellows must communicate with the supervising
1375 faculty member(s). ^(Core)

1376
1377 **VI.A.2.e).(1)** Each fellow must know the limits of their scope of
1378 authority, and the circumstances under which the
1379 fellow is permitted to act with conditional
1380 independence. ^(Outcome)

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

1382
1383 **VI.A.2.f)** Faculty supervision assignments must be of sufficient
1384 duration to assess the knowledge and skills of each fellow
1385 and to delegate to the fellow the appropriate level of patient
1386 care authority and responsibility. ^(Core)

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1388 **VI.B. Professionalism**

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1390 **VI.B.1.** Programs, in partnership with their Sponsoring Institutions, must
1391 educate fellows and faculty members concerning the professional
1392 responsibilities of physicians, including their obligation to be
1393 appropriately rested and fit to provide the care required by their
1394 patients. ^(Core)

1395
1396 **VI.B.2.** The learning objectives of the program must:

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1398 **VI.B.2.a)** be accomplished through an appropriate blend of supervised
1399 patient care responsibilities, clinical teaching, and didactic
1400 educational events; ^(Core)

1401
1402 **VI.B.2.b)** be accomplished without excessive reliance on fellows to
1403 fulfill non-physician obligations; and, ^(Core)

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.

1405
1406 **VI.B.2.c)** ensure manageable patient care responsibilities. ^(Core)

1407

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

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

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

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

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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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1423

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

1424

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

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

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

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

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1441 VI.B.5. All fellows and faculty members must demonstrate responsiveness
1442 to patient needs that supersedes self-interest. This includes the
1443 recognition that under certain circumstances, the best interests of
1444 the patient may be served by transitioning that patient's care to
1445 another qualified and rested provider. (Outcome)
1446

1447 VI.B.6. Programs, in partnership with their Sponsoring Institutions, must
1448 provide a professional, equitable, respectful, and civil environment
1449 that is free from discrimination, sexual and other forms of
1450 harassment, mistreatment, abuse, or coercion of students, fellows,
1451 faculty, and staff. (Core)
1452

1453 VI.B.7. Programs, in partnership with their Sponsoring Institutions, should
1454 have a process for education of fellows and faculty regarding
1455 unprofessional behavior and a confidential process for reporting,
1456 investigating, and addressing such concerns. (Core)
1457

1458 VI.C. Well-Being

1459 *Psychological, emotional, and physical well-being are critical in the*
1460 *development of the competent, caring, and resilient physician and require*
1461 *proactive attention to life inside and outside of medicine. Well-being*
1462 *requires that physicians retain the joy in medicine while managing their*
1463 *own real life stresses. Self-care and responsibility to support other*
1464 *members of the health care team are important components of*
1465 *professionalism; they are also skills that must be modeled, learned, and*
1466 *nurtured in the context of other aspects of fellowship training.*
1467
1468

1469 *Fellows and faculty members are at risk for burnout and depression.*
1470 *Programs, in partnership with their Sponsoring Institutions, have the same*
1471 *responsibility to address well-being as other aspects of resident*
1472 *competence. Physicians and all members of the health care team share*
1473 *responsibility for the well-being of each other. For example, a culture which*
1474 *encourages covering for colleagues after an illness without the expectation*
1475 *of reciprocity reflects the ideal of professionalism. A positive culture in a*
1476 *clinical learning environment models constructive behaviors, and prepares*
1477 *fellows with the skills and attitudes needed to thrive throughout their*
1478 *careers.*
1479

Background and Intent: The ACGME is committed to addressing physician well-being for individuals and as it relates to the learning and working environment. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians' ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and collaboration. Information regarding the ACGME's ongoing efforts in this area is available on the ACGME website.

As these efforts evolve, information will be shared with programs seeking to develop and/or strengthen their own well-being initiatives. In addition, there are many activities that programs can utilize now to assess and support physician well-being. These

include culture of safety surveys, ensuring the availability of counseling services, and attention to the safety of the entire health care team.

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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; ^(Core)

VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts fellow well-being; ^(Core)

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

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, ^(Core)

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.

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

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.

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VI.C.1.e) attention to fellow and faculty member burnout, depression, and substance use disorder. The program, in partnership with its Sponsoring Institution, must educate faculty members and fellows in identification of the symptoms of burnout, depression, and substance use disorder, including means to assist those who experience these conditions. Fellows and

1514 faculty members must also be educated to recognize those
1515 symptoms in themselves and how to seek appropriate care.
1516 The program, in partnership with its Sponsoring Institution,
1517 must: ^(Core)
1518

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

1519
1520 VI.C.1.e).(1) encourage fellows and faculty members to alert the
1521 program director or other designated personnel or
1522 programs when they are concerned that another
1523 fellow, resident, or faculty member may be displaying
1524 signs of burnout, depression, a substance use
1525 disorder, suicidal ideation, or potential for violence;
1526 ^(Core)
1527

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.

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1529 VI.C.1.e).(2) provide access to appropriate tools for self-screening;
1530 and, ^(Core)
1531

1532 VI.C.1.e).(3) provide access to confidential, affordable mental
1533 health assessment, counseling, and treatment,
1534 including access to urgent and emergent care 24
1535 hours a day, seven days a week. ^(Core)
1536

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.

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

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.

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- VI.D. Fatigue Mitigation**
- VI.D.1. Programs must:**
- VI.D.1.a)** educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation; ^(Core)
- VI.D.1.b)** educate all faculty members and fellows in alertness management and fatigue mitigation processes; and, ^(Core)
- VI.D.1.c)** encourage fellows to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. ^(Detail)

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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- 1567 **VI.D.2.** Each program must ensure continuity of patient care, consistent
 1568 with the program’s policies and procedures referenced in VI.C.2–
 1569 VI.C.2.b), in the event that a fellow may be unable to perform their
 1570 patient care responsibilities due to excessive fatigue. ^(Core)
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- 1572 **VI.D.3.** The program, in partnership with its Sponsoring Institution, must
 1573 ensure adequate sleep facilities and safe transportation options for
 1574 fellows who may be too fatigued to safely return home. ^(Core)
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- 1576 **VI.E.** Clinical Responsibilities, Teamwork, and Transitions of Care
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- 1578 **VI.E.1.** Clinical Responsibilities
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 1580 The clinical responsibilities for each fellow must be based on PGY
 1581 level, patient safety, fellow ability, severity and complexity of patient
 1582 illness/condition, and available support services. ^(Core)
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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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- 1585 **VI.E.2.** Teamwork
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 1587 Fellows must care for patients in an environment that maximizes
 1588 communication. This must include the opportunity to work as a
 1589 member of effective interprofessional teams that are appropriate to
 1590 the delivery of care in the subspecialty and larger health system.
 1591 ^(Core)
 1592
- 1593 **VI.E.3.** Transitions of Care
 1594
- 1595 **VI.E.3.a)** Programs must design clinical assignments to optimize
 1596 transitions in patient care, including their safety, frequency,
 1597 and structure. ^(Core)
 1598
- 1599 **VI.E.3.b)** Programs, in partnership with their Sponsoring Institutions,
 1600 must ensure and monitor effective, structured hand-over
 1601 processes to facilitate both continuity of care and patient
 1602 safety. ^(Core)
 1603
- 1604 **VI.E.3.c)** Programs must ensure that fellows are competent in
 1605 communicating with team members in the hand-over process.
 1606 ^(Outcome)
 1607

1608 VI.E.3.d) Programs and clinical sites must maintain and communicate
1609 schedules of attending physicians and fellows currently
1610 responsible for care. ^(Core)

1611
1612 VI.E.3.e) Each program must ensure continuity of patient care,
1613 consistent with the program’s policies and procedures
1614 referenced in VI.C.2-VI.C.2.b), in the event that a fellow may
1615 be unable to perform their patient care responsibilities due to
1616 excessive fatigue or illness, or family emergency. ^(Core)

1617
1618 VI.F. Clinical Experience and Education

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1620 *Programs, in partnership with their Sponsoring Institutions, must design*
1621 *an effective program structure that is configured to provide fellows with*
1622 *educational and clinical experience opportunities, as well as reasonable*
1623 *opportunities for rest and personal activities.*

1624
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.

1625
1626 VI.F.1. Maximum Hours of Clinical and Educational Work per Week

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1628 Clinical and educational work hours must be limited to no more than
1629 80 hours per week, averaged over a four-week period, inclusive of all
1630 in-house clinical and educational activities, clinical work done from
1631 home, and all moonlighting. ^(Core)

1632
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. ^(Core)

1641 VI.F.2.b) Fellows should have eight hours off between scheduled
1642 clinical work and education periods. ^(Detail)

1643
1644 VI.F.2.b).(1) There may be circumstances when fellows choose to
1645 stay to care for their patients or return to the hospital
1646 with fewer than eight hours free of clinical experience
1647 and education. This must occur within the context of
1648 the 80-hour and the one-day-off-in-seven
1649 requirements. ^(Detail)
1650

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.

1651 VI.F.2.c) Fellows must have at least 14 hours free of clinical work and
1652 education after 24 hours of in-house call. ^(Core)
1653
1654

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.

1655 VI.F.2.d) Fellows must be scheduled for a minimum of one day in
1656 seven free of clinical work and required education (when
1657 averaged over four weeks). At-home call cannot be assigned
1658 on these free days. ^(Core)
1659
1660

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."

1661 VI.F.3. Maximum Clinical Work and Education Period Length
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1664 VI.F.3.a) Clinical and educational work periods for fellows must not
1665 exceed 24 hours of continuous scheduled clinical
1666 assignments. ^(Core)

1667
1668 VI.F.3.a).(1) Up to four hours of additional time may be used for
1669 activities related to patient safety, such as providing
1670 effective transitions of care, and/or fellow education.
1671 ^(Core)

1672
1673 VI.F.3.a).(1).(a) Additional patient care responsibilities must not
1674 be assigned to a fellow during this time. ^(Core)
1675

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.

1676
1677 VI.F.4. Clinical and Educational Work Hour Exceptions
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1679 VI.F.4.a) In rare circumstances, after handing off all other
1680 responsibilities, a fellow, on their own initiative, may elect to
1681 remain or return to the clinical site in the following
1682 circumstances:

1683
1684 VI.F.4.a).(1) to continue to provide care to a single severely ill or
1685 unstable patient; ^(Detail)

1686
1687 VI.F.4.a).(2) humanistic attention to the needs of a patient or
1688 family; or, ^(Detail)

1689
1690 VI.F.4.a).(3) to attend unique educational events. ^(Detail)

1691
1692 VI.F.4.b) These additional hours of care or education will be counted
1693 toward the 80-hour weekly limit. ^(Detail)
1694

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.

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1696 VI.F.4.c) A Review Committee may grant rotation-specific exceptions
1697 for up to 10 percent or a maximum of 88 clinical and

1698 educational work hours to individual programs based on a
1699 sound educational rationale.

1700
1701 The Review Committee for Neurology will not consider requests
1702 for exceptions to the 80-hour limit to the fellows' work week.
1703

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1705 **VI.F.5. Moonlighting**

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1707 **VI.F.5.a) Moonlighting must not interfere with the ability of the fellow
1708 to achieve the goals and objectives of the educational
1709 program, and must not interfere with the fellow's fitness for
1710 work nor compromise patient safety. (Core)**

1711
1712 **VI.F.5.b) Time spent by fellows in internal and external moonlighting
1713 (as defined in the ACGME Glossary of Terms) must be
1714 counted toward the 80-hour maximum weekly limit. (Core)**
1715

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>).

1716
1717 **VI.F.6. In-House Night Float**

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1719 **Night float must occur within the context of the 80-hour and one-
1720 day-off-in-seven requirements. (Core)**
1721

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.

1722
1723 **VI.F.7. Maximum In-House On-Call Frequency**

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1725 **Fellows must be scheduled for in-house call no more frequently than
1726 every third night (when averaged over a four-week period). (Core)**
1727

1728 **VI.F.8. At-Home Call**

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1730 **VI.F.8.a) Time spent on patient care activities by fellows on at-home
1731 call must count toward the 80-hour maximum weekly limit.
1732 The frequency of at-home call is not subject to the every-
1733 third-night limitation, but must satisfy the requirement for one
1734 day in seven free of clinical work and education, when
1735 averaged over four weeks. (Core)**
1736

1737 **VI.F.8.a).(1) At-home call must not be so frequent or taxing as to
1738 preclude rest or reasonable personal time for each
1739 fellow. (Core)**

1740
1741 **VI.F.8.b) Fellows are permitted to return to the hospital while on at-
1742 home call to provide direct care for new or established**

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patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. ^(Detail)

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

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

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

Osteopathic Recognition

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