ACGME Program Requirements for Graduate Medical Education in Pain Medicine including FAQs

Revision Information

Frequently asked questions (FAQs) incorporated into the Requirements July 1, 2026; effective July 1, 2026

ACGME-approved interim revision February 9, 2026; effective immediately. Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirements 1.3.a., 2.2.a., 2.7.c., 4.2.a., 4.2.e., 5.5.f., 5.5.h., 6.24., and 6.24.a. has been suspended. See explanatory text under 1.2. for modifications to this and related specialty-specific requirements.

ACGME-approved interim revision September 29, 2025; effective July 1, 2026

Definitions

For more information, see the ACGME Glossary of Terms.

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).

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ACGME Program Requirements for Graduate Medical Education

in Pain Medicine

Common Program Requirements (Fellowship) are in BOLD

Where applicable, italicized text is used to provide definitions or describe the underlying philosophy of the requirements in that section. These statements are not program requirements and are therefore not citable.

> **Background and Intent: These fellowship requirements reflect the fact that these learners have already completed the first phase of graduate medical education. Thus, the Common Program Requirements (Fellowship) are intended to explain the differences.**

Introduction

Definition of Graduate Medical Education

Fellowship is advanced graduate medical education beyond a core residency program for physicians who desire to enter more specialized practice. Fellowship-trained physicians serve the public by providing subspecialty care, which may also include core medical care, acting as a community resource for expertise in their field, creating and integrating new knowledge into practice, and educating future generations of physicians. Graduate medical education values the strength that a heterogeneous group of physicians brings to medical care, and the importance of accessible and psychologically safe learning environments.

Fellows who have completed residency are able to practice autonomously in their core specialty. The prior medical experience and expertise of fellows distinguish them from physicians entering residency. The fellow's care of patients within the subspecialty is undertaken with appropriate faculty supervision and conditional independence. Faculty members serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship. The fellow develops deep medical knowledge, patient care skills, and expertise applicable to their focused area of practice. Fellowship is an intensive program of subspecialty clinical and didactic education that focuses on the multidisciplinary care of patients. Fellowship education is often physically, emotionally, and intellectually demanding, and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.

In addition to clinical education, many fellowship programs advance fellows' skills as physician-scientists. While the ability to create new knowledge within medicine is not exclusive to fellowship-educated physicians, the fellowship experience expands a physician's abilities to pursue hypothesis-driven scientific inquiry that results in contributions to the medical literature and patient care. Beyond the clinical subspecialty expertise ach-

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ieved, fellows develop mentored relationships built on an infrastructure that promotes collaborative research.

Definition of Subspecialty

Pain medicine is the discipline of medicine that specializes in the management of patients suffering from acute or chronic pain, or pain in patients requiring palliative care. The management of acute and chronic pain syndromes is a complex matter involving many areas of interest and different medical disciplines. Clinical and investigative efforts are vital to the progress of the specialty. Fellows may originate from different disciplines and approach the field with varying backgrounds and experience. All pain specialists, regardless of their primary specialty, should be competent in pain assessment, formulation, and coordination of a multiple modality treatment plan, integration of pain treatment with primary disease management and palliative care, and interaction with other members of a multidisciplinary team. Therefore, the didactic and clinical curriculum of the pain is designed to address attainment of these Competencies.

Section 1: Oversight

Sponsoring Institution

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

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

> **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.**

1.1. The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)

Participating Sites

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

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

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1.2.a. Only multidisciplinary programs will be accredited. A multidisciplinary program in pain medicine must be conducted in an institution and/or its participating sites that sponsor(s) ACGME-accredited residencies in at least one of the following specialties: anesthesiology; physical medicine and rehabilitation; and child neurology or neurology. (Core)

1.2.a.1. Programs must adequately demonstrate their commitment to the multidisciplinary nature of the specialty with applicable faculty member appointments. (Core)

1.2.b. There must be an institutional policy governing the educational resources committed to pain medicine that ensures cooperation of all the involved disciplines. There must be a multidisciplinary fellowship committee to regularly review the program's resources and its attainment of stated goals and objectives. (Core)

1.3. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)
[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]

1.3.a. The PLA must be renewed at least every 10 years. (Core)

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 1.3.a has been suspended]

1.3.b. The PLA must be approved by the designated institutional official (DIO). (Core)

Background and Intent: While all residency 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 ensure the quality of the educational experience.

Suggested elements to be considered in PLAs will be found in the Guide to the Common Program Requirements. These include:

- **Identifying the faculty members who will assume educational and supervisory responsibility for residents**
- **Specifying the responsibilities for teaching, supervision, and formal evaluation of residents**
- **Specifying the duration and content of the educational experience**
- **Stating the policies and procedures that will govern resident education during the assignment**

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

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

Background and Intent: While all fellowship programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must designate a faculty member responsible for ensuring the quality of the educational experience. In some circumstances, the person charged with this responsibility may not be physically present at the site, but remains responsible for fellow education occurring at the site.

Suggested elements to be considered in PLAs will be found in the 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**

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

1.7. Resources

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

1.7.a. Space and Equipment

The following facilities and equipment must be available to the program: (Core)

1.7.a.1. a pain center offering subspecialty education, designed specifically for the management of pain patients; and, (Core)

1.7.a.2. appropriate monitoring and life support equipment immediately available wherever invasive pain management procedures are performed. (Core)

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1.7.b. Space for research and teaching conferences in pain medicine must be available. (Core)

1.7.c. There must be appropriate on-call facilities for all fellows and faculty members. (Core)

1.7.d. Support Services
The following functions and support must be available:

1.7.d.1. appropriate radiologic imaging facilities; (Core)

1.7.d.2. psychiatric/psychological services, including behavioral modification; (Core)

1.7.d.3. physical and/or occupational therapy; (Core)

1.7.d.4. social services; and, (Core)

1.7.d.5. appropriate electrodiagnostic facilities. (Core)

1.7.e. Patient Population (Clinical Resources)
There should be, within the patient population, a wide variety of clinical pain problems to allow fellows to develop broad clinical skills and knowledge required for a specialist in pain medicine. (Core)

1.8. 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:

1.8.a. access to food while on duty; (Core)

1.8.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.

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

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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 6.13.c.1.

1.8.d. **security and safety measures appropriate to the participating site; and, (Core)**

1.8.e. **accommodations for fellows with disabilities consistent with the Sponsoring Institution's policy. (Core)**

1.9. **Fellows must have ready access to subspecialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)**

1.10. **Other Learners and Health Care Personnel**

The presence of other learners and other health care personnel, including but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed fellows' education. (Core)

Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and postgraduate 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.

Section 2: Personnel

2.1. **Program Director**

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

2.2. **The Sponsoring Institution's Graduate Medical Education Committee (GMEC) must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core)**

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2.2.a. Final approval of the program director resides with the Review Committee. **(Core)**

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 2.2.a has been suspended. It is noted that appointment of a program director who does not meet the Common Program Requirements and specialty specific requirements related to minimum qualifications of the program director may result in citation(s) for non-compliance with those requirements]

Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a fellowship, a single individual must be designated as program director and have overall responsibility for the program. The program director's nomination is reviewed and approved by the GMEC.

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

2.3.a. Program leadership, in aggregate, must be provided with support equal to a dedicated minimum time specified below for administration of the program. This may be time spent by the program director only or divided between the program director and one or more associate (or assistant) program directors. (Core)

Number of Approved Fellow Positions	Minimum Support Required (FTE)
1-2	0.1
3-5	0.15
6 or more	0.2

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

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

The program director and, as applicable, the program leadership team, devote a portion of their professional effort to the oversight and management of the fellowship program, as defined in 2.5. - 2.5.l. Both provision of support for the time required for the leadership effort and flexibility regarding how this support is provided are important. Programs, in part-

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nership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.

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

In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a *minimum*, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program director, is also addressed in Institutional Requirement 2.2.a. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program directors to fulfill their program responsibilities effectively.

2.4. Qualifications of the Program Director

The program director must possess subspecialty expertise and qualifications acceptable to the Review Committee. (Core)

[See FAQ in Appendix]

2.4.a. The program director must possess current certification in the subspecialty for which they are the program director by the American Board of Anesthesiology, Physical Medicine and Rehabilitation, or Psychiatry and Neurology, **the American Osteopathic Board of** Anesthesiology, or a member board of the American Osteopathic Conjoint Pain Medicine Examination Committee**, or subspecialty qualifications that are acceptable to the Review Committee. (Core)**

Subspecialty-Specific Background and Intent: This requirement refers to certification in the subspecialty of pain medicine and includes reference to all ABMS member boards and AOA certifying boards that offer this certification. It is recognized that some certifying boards may offer certification in pain medicine to individuals with primary certification in a specialty not listed in 2.4.a., and the requirement above should not be interpreted to mean that only individuals with primary certification by one of the boards listed above are eligible to serve as a program director of a pain medicine fellowship.

[See FAQ in Appendix]

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2.4.b. The program director must have documentation of ongoing academic achievements appropriate to the subspecialty, including publications, the development of educational programs, or the conduct of research. (Core)

2.5. Program Director Responsibilities

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

2.5.a. The program director must be a role model of professionalism. (Core)

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.

2.5.b. The program director must design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program. (Core)

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 eliminating health disparities.

2.5.c. The program director must administer and maintain a learning environment conducive to educating the fellows in each of the ACGME Competency domains. (Core)

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

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2.5.d. **The program director must have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval.** (Core)

Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of fellows by non-physician educators may enable the fellows to better manage patient care and provides valuable advancement of the fellows' knowledge. Furthermore, other individuals contribute to the education of fellows 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.

2.5.e. **The program director must have the authority to remove fellows from supervising interactions and/or learning environments that do not meet the standards of the program.** (Core)

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.

2.5.f. **The program director must submit accurate and complete information required and requested by the DIO, GMEC, and ACGME.** (Core)

Background and Intent: This includes providing information in the form and format requested by the ACGME and obtaining requisite sign-off by the DIO.

2.5.g. **The program director must provide a learning and working environment in which fellows have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation.** (Core)

2.5.h. **The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, not to promote, or renew the appointment of a fellow.** (Core)

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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.

2.5.i. **The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination. (Core)**

2.5.j. **The program director must document verification of education for all fellows within 30 days of completion of or departure from the program. (Core)**

2.5.k. **The program director must provide verification of an individual fellow's education upon the fellow's request, within 30 days. (Core)**

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.

2.5.l. **The program director must provide applicants who are offered an interview with information related to their eligibility for the relevant specialty board examination(s). (Core)**

Faculty

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

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

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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.

2.6. There must be a sufficient number of faculty members with competence to instruct and supervise all fellows. (Core)

2.6.a. At least three faculty members with expertise in pain medicine, including the program director, must be involved in pain medicine subspecialty education, and these must equal at least two FTEs. (Core)

2.6.b. The faculty must include psychiatrists or clinical psychologists who have documented experience in the evaluation and treatment of patients with chronic pain. (Core)

2.7. Faculty Responsibilities
Faculty members must be role models of professionalism. (Core)

2.7.a. Faculty members must demonstrate commitment to the delivery of safe, high-quality, cost-effective, patient-centered care. (Core)

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.

2.7.b. Faculty members must demonstrate a strong interest in the education of fellows, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. (Core)

2.7.c. Faculty members must administer and maintain an educational environment conducive to educating fellows. (Core)

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 2.7.c. has been suspended.]

2.7.d. Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Core)

2.7.e. Faculty members must pursue faculty development designed to enhance their skills at least annually. (Core)

Background and Intent: Faculty development is intended to describe structured programming developed for the purpose of enhancing transfer-

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ence 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.

2.8. Faculty Qualifications

Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

2.9. Subspecialty Physician Faculty Members

Subspecialty physician faculty members must have current certification in the subspecialty by the American Board of Anesthesiology, Physical Medicine and Rehabilitation, or Psychiatry and Neurology, **or the American Osteopathic Board of** Anesthesiology, or a member board of the American Osteopathic Conjoint Pain Medicine Examination Committee**, or possess qualifications judged acceptable to the Review Committee.** (Core)

2.9.a. Any other specialty or subspecialty physician faculty members must have current certification in their specialty or subspecialty 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)

Background and Intent: The ACGME expects that physician faculty members (especially core and other required faculty members) have current certification in the specialty or subspecialty by the relevant ABMS member board and/or AOA certifying board. However, in certain instances when a physician faculty member was never eligible for initial certification in the US by one of these entities, programs will be considered in compliance if all the following qualifications are met. The physician faculty member:

1. **completed residency or fellowship in the relevant specialty or subspecialty;**
2. **held board certification (if available) in the country where they trained or practiced, if outside the US;**
3. **holds full and unrestricted licensure to practice medicine in the state where the program is located;**
4. **has three years of experience in practice (after residency/fellowship) in the US, in the specialty or subspecialty for which they will serve as a physician faculty member;**
5. **meets standards of professionalism;**
6. **has demonstrated clinical qualifications and satisfactory patient outcomes; and,**

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7. **fulfills at least one of the following: a) demonstrated participation in additional clinical or research training in the specialty or subspecialty; b) demonstrated scholarship in the specialty or subspecialty; c) demonstrated leadership during or after residency/fellowship.**

[See FAQ in Appendix]

2.9.a.1. The faculty must include members who completed an ACGME-accredited or AOA-approved program in at least two of the following specialties: anesthesiology; physical medicine and rehabilitation; psychiatry; and child neurology or neurology. (Core)

2.9.a.1.a. These faculty members must have qualifications acceptable to the Review Committee. (Core)

2.9.b. The faculty as a whole must possess expertise across the domains of acute and chronic pain and pain in patients who require palliative care. (Core)

2.10. Core Faculty

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

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

2.10.a. Faculty members must complete the annual ACGME Faculty Survey. (Core)

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2.10.b. There must be a ratio of at least one FTE core faculty member (salaried or non-salaried) to two fellows. (Core)

2.11. Program Coordinator

There must be a program coordinator. (Core)

2.11.a. The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)

2.11.b. At a minimum, the program coordinator must be supported at 20 percent FTE for administration of the program. Additional support must be provided based on program size as follows: (Core)

Number of Approved Fellow Positions	Minimum FTE Coordinator(s) Required
2	0.22
3	0.24
4	0.26
5	0.28
>5	Additional 0.02 FTE per fellow

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

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

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

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

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The minimum required dedicated time and support specified in 2.11.b. includes activities directly related to administration of the accredited program. It is understood that coordinators often have additional responsibilities, beyond those directly related to program administration, including, but not limited to, departmental administrative responsibilities, medical school clerkships, planning lectures that are not solely intended for the accredited program, and mandatory reporting for entities other than the ACGME. Assignment of these other responsibilities will necessitate consideration of allocation of additional support so as not to preclude the coordinator from devoting the time specified above solely to administrative activities that support the accredited program.

In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a minimum, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program coordinator, is also addressed in Institutional Requirement 2.2.d. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program coordinators to fulfill their program responsibilities effectively.

2.12. Other Program Personnel

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

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.

Section 3: Fellow Appointments

3.1. Fellows must not be required to sign a non-competition guarantee or restrictive covenant. (Core)

3.2. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, an AOA-

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approved residency program, a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or a Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency program located in Canada. (Core)

[See FAQ in Appendix]

3.2.a. Fellowship programs must receive verification of each entering fellow's level of competence in the required field using ACGME, ACGME-I, or CanMEDS Milestones evaluations from the core residency program. (Core)

Background and Intent: A reporting feature is available for fellowship programs within ADS to provide fellowship program directors access to the final Milestones report for an active fellow's most recently completed residency program. These reports are available to fellowship program directors in mid-July, and use of this system to retrieve the reports is encouraged. There are a few scenarios in which these reports may not be available, such as if a fellow completed residency in a program not accredited by the ACGME, if a fellow completed residency prior to Milestones implementation, or if a fellow's previous experience could not be matched when entered into the program. For those without Milestones reports, programs must contact the specialty program director from the fellow's most recent residency program to obtain the required information. This new reporting feature can be found in ADS by logging in and navigating to the program's "Reports" tab, and then selecting the "Residency Milestone Retrieval" option.

3.2.a.1. Prior to appointment in the programs, fellows should have completed a residency program that satisfies 3.2. (Core)

Subspecialty-Specific Background and Intent: Physicians in many specialties can benefit from pain medicine training, so the ACGME permits a resident from any specialty that has met the requirements below to enroll in a pain program. Not every certifying board will recognize pain subspecialty education, so the individual resident and the program director are responsible for determining individual board eligibility with the respective certifying board prior to enrollment in the pain program.

The Review Committee for Anesthesiology also permits pain medicine program directors to accept "exceptional candidates" as fellows who did not complete a residency in an ACGME-accredited program. This exception allows physicians from international programs to benefit from the educational program in pain medicine. While these fellows will complete the Program Requirements for Pain Medicine, they will not be candidates for board certification from a board sponsored by the ABMS (American Board of Medical Specialties), the AOBA (Amer-

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ican Osteopathic Board of Anesthesiology), or AOCPC (American Osteopathic Conjoint Pain Examination Committee).

3.2.b. Fellow Eligibility Exception

The Review Committee for Anesthesiology **will allow the following exception to the fellowship eligibility requirements:**

3.2.b.1. An ACGME-accredited fellowship program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in 3.2., but who does meet all of the following additional qualifications and conditions: (Core)

3.2.b.1.a. evaluation by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and, (Core)

3.2.b.1.b. review and approval of the applicant's exceptional qualifications by the GMEC; and, (Core)

[See FAQ in Appendix]

3.2.b.1.c. verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification. (Core)

3.2.b.2. Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. (Core)

Background and Intent: An exceptionally qualified international graduate applicant has (1) completed a residency program in the core specialty outside the continental United States that was not accredited by the ACGME, AOA, ACGME-I, RCPSC or CFPC, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; and/or (c) demonstrated leadership during or after residency. Applicants being considered for these positions must be informed of the fact that their training may not lead to certification by ABMS member boards or AOA certifying boards.

In recognition of the range of medical 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.

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3.3. Fellow Complement

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

Background and Intent: Programs are required to request approval of all complement changes, whether temporary or permanent, by the Review Committee through ADS. Permanent increases require prior approval from the Review Committee and temporary increases may also require approval. Specialty-specific instructions for requesting a complement increase are found in the "Documents and Resources" page of the applicable specialty section of the ACGME website.

3.4. Fellow Transfers

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

3.5. Prior to accepting a transfer fellow, the program must obtain from the fellow, and retain written confirmation that the fellow understands the impact of the transfer on their eligibility for their intended specialty board's initial certification. (Core)

Section 4: Educational Program

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

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

It is recognized that programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.

4.1. Length of Program

The educational program in pain medicine must be 12 months in length. (Core)

4.2. Educational Components

The curriculum must contain the following educational components:

4.2.a. a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities

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of its graduates, which must be made available to program applicants, fellows, and faculty members; (Core)

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 4.2.a. has been suspended]

4.2.b. **competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice in their subspecialty. These must be distributed, reviewed, and available to fellows and faculty members; (Core)**

4.2.c. **delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and graded supervision in their subspecialty; (Core)**

> **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.**

4.2.d. **structured educational activities beyond direct patient care; and, (Core)**

> **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 4.10. – 4.12.**

4.2.e. **formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)**

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 4.2.e. has been suspended]

ACGME Competencies

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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The program must integrate all ACGME Competencies into the curriculum.

4.3. ACGME Competencies – Professionalism

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

4.4. ACGME Competencies – Patient Care and Procedural Skills (Part A)

Fellows must be able to provide patient care that is patient- and family-centered, compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)

Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, fair, and designed to improve population health, while reducing per capita costs. 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.

[See FAQ in Appendix] [See FAQ in Appendix]

4.4.a. Fellows must demonstrate competence in eliciting a detailed neurological history. (Core)

4.4.b. Fellows must demonstrate competence in performing a detailed neurological examination to include at least mental status, cranial nerves, motor, sensory, reflex, cerebellum examinations, and gait in patients. (Core)

4.4.c. Fellows must demonstrate competence in identifying significant findings of basic neuro-imaging. (Core)

4.4.c.1. Neuro-imaging studies must include at least magnetic resonance imaging (MRI) and computerized tomography (CT) of the spine and brain. (Core)

4.4.c.2. Neuro-imaging studies must be drawn from the following areas: brain; cervical; thoracic; and lumbar spine. (Core)

4.4.c.3. Neuro-imaging study training must be verified by a faculty member from an ACGME-accredited residency program in child neurology/neurology, neurological surgery, or radiology, or by a faculty member with qualifications acceptable to the Review Committee. (Detail)

[See FAQ in Appendix]

4.4.d. Fellows must demonstrate competence in performing a comprehensive musculoskeletal and appropriate neuromuscular history and examination with emphasis on both structure and function as it applies to diagnosing acute and chronic pain problems. (Core)

4.4.e. Fellows must demonstrate competence in identifying and prescribing rehabilitation interventions for specific spine and musculoskeletal conditions. (Core)

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4.4.f. Fellows must demonstrate competence in developing patient rehabilitation programs to include assessments of static and dynamic flexibility, strength, coordination, and agility for peripheral joint, spinal, and soft tissue pain conditions; including proficiency in the clinical evaluation and development of a rehabilitation plan. (Core)

4.4.g. Fellows must demonstrate competence in identifying patients best suited for multidisciplinary team pain management, to include patients with psychiatric and psychosocial risk factors and designing patient-specific programs in these situations. (Core)

4.4.h. Fellows must demonstrate competence in integrating therapeutic modalities and surgical intervention in the treatment algorithm. (Core)

4.4.i. Fellows must demonstrate competence in carrying out a complete and detailed psychiatric history with special attention to psychiatric and pain comorbidities. (Core)

4.4.j. Fellows must demonstrate competence in conducting a complete mental status examination. (Core)

4.4.k. Fellows must demonstrate competence in explaining psychosocial therapy to a patient and making a referral when indicated. (Core)

4.5. ACGME Competencies – Patient Care and Procedural Skills (Part B)
Fellows must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)

4.5.a. Fellows must demonstrate competence in obtaining intravenous access. (Core)

4.5.b. Fellows must demonstrate competence in basic airway management that at a minimum includes competency in mask ventilation. (Core)

4.5.c. Fellows must demonstrate competence in advanced airway management. (Core)

4.5.c.1. This must include experience with laryngeal mask airway and/or endotracheal intubation as a back-up if mask ventilation is unsuccessful. (Core)
[See FAQ in Appendix]

4.5.d. Fellows must demonstrate competence in basic life support and advanced cardiac life support. (Core)
[See FAQ in Appendix]

4.5.e. Fellows must demonstrate competence in management of sedation, including exposure to administration of moderate procedural sedation. (Core)

4.5.f. Fellows must demonstrate competence in recognizing and managing physiologic perturbations associated with neuraxial anesthesia/analgesia, including development of motor and sensory loss and cardiovascular and respiratory changes. (Core)

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4.5.g. Fellows must demonstrate competence in recognizing and managing physiologic perturbations associated with intravascular injection of local anesthetics, including mental status changes, seizure, and cardiovascular collapse. (Core)

4.5.h. Fellows must demonstrate competence in performing interventional treatments, including:(Core).

4.5.h.1. epidural injections, to include interlaminar, transforaminal, and caudal; (Detail)

4.5.h.2. trigger point injections; (Detail)

4.5.h.3. facet and medial branch blocks; (Detail)

4.5.h.4. neuroablative procedures; (Detail)

4.5.h.5. joint and bursa injections; (Detail)

4.5.h.6. sympathetic blocks; (Detail)

4.5.h.7. peripheral nerve blocks; and, (Detail)

4.5.h.8. understanding psychosocial risk factors that contraindicate permanent interventional procedures in patients with chronic pain. (Core)

4.5.i. Fellows must demonstrate competence in a range of direct, hands-on interventional pain treatment techniques. (Core)

4.5.j. Fellows must demonstrate competence in neuromodulation and managing intervertebral disc procedures (e.g., spinal cord stimulation, peripheral nerve stimulation, electrical stimulation, and targeted drug delivery). (Detail)

4.5.k. Fellows must demonstrate competence in interventional procedures and processes, including the following management skills: (Core)

4.5.k.1. recognizing risks and complications; (Detail)

4.5.k.2. obtaining a complete informed consent identifying the appropriate risks and potential benefits of each procedure, including sedation; (Detail)

4.5.k.3. identifying and mitigating risks for the following intervening factors: infection risk, opioid use, including the use of antagonists, anti-coagulation, pacemaker, and other implanted devices; and, (Detail)

4.5.k.4. managing patients receiving opioids, including an understanding of opioid agreements, risk mitigation tools, and appropriate use of drug screening. (Core)

4.5.l. Fellows must demonstrate competence in recognizing substance use disorders, including associated stigma. (Detail)

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4.5.m. Fellows must demonstrate competence in identifying and implementing treatment options for substance use disorder, including medication-assisted treatment for Opioid Use Disorder. (Detail)

4.6. ACGME Competencies – Medical Knowledge

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

4.6.a. Fellows must demonstrate competence in their knowledge of assessment of pain, including: (Core)

4.6.a.1. anatomy, physiology, and pharmacology of pain transmission and modulation; (Core)

4.6.a.2. natural history of various musculoskeletal pain disorders; (Core)

4.6.a.3. general principles of pain evaluation and management, to include neurological exam, musculoskeletal exam, and psychological assessment; (Core)

4.6.a.4. indicators and interpretation of electro-diagnostic studies, to include: X-Rays; MRI; CT; and clinical nerve function studies; (Core)

4.6.a.5. pain measurement in humans, both experimental and clinical; (Core)

4.6.a.6. psychosocial aspects of pain, to include cultural and cross-cultural considerations; (Core)

4.6.a.7. taxonomy of pain syndromes; (Core)

4.6.a.8. pain of spinal origin, to include radicular pain, zygapophysial joint disease, and discogenic pain; (Core)

4.6.a.9. myofascial pain; (Core)

4.6.a.10. neuropathic pain; (Core)

4.6.a.11. headache and orofacial pain; (Core)

4.6.a.12. rheumatological aspects of pain; (Core)

4.6.a.13. complex regional pain syndromes; (Core)

4.6.a.14. visceral pain; (Core)

4.6.a.15. urogenital pain; (Core)

4.6.a.16. cancer pain, including palliative and hospice care; (Core)
[See FAQ in Appendix]

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4.6.a.17. acute pain; (Core)

4.6.a.18. frequent psychiatric and pain co-morbidities, to include substance-related mood, anxiety, somatoform, factitious, and personality disorders; (Core)

4.6.a.19. the effects of pain medications on mental status; (Core)

4.6.a.20. assessment of pain in special populations, to include patients with ongoing substance use disorders, the elderly, pediatric patients, pregnant women, the physically disabled, and the cognitively impaired; and, (Core)

4.6.a.21. functional and disability assessment. (Core)

4.6.b. Fellows must demonstrate competence in their knowledge of treatment of pain, including: (Core)

4.6.b.1. drug treatment with antidepressants, anticonvulsants, and miscellaneous drugs; (Core)

4.6.b.2. drug treatment with nonsteroidal anti-inflammatory drugs; (Core)

4.6.b.3. drug treatment with opioids. (Core)

4.6.b.4. systemic opioids, to include management of acute or chronic pain in the opioid tolerant patient; (Core)

4.6.b.5. systemic opioids, to include pharmacokinetics of opioid analgesics, including bioavailability, absorption, distribution, metabolism, and excretion; (Core)

4.6.b.6. systemic opioids, to include mechanism of action; (Core)

4.6.b.7. systemic opioids, to include chemical structure; (Core)

4.6.b.8. systemic opioids, to include mechanisms, uses, and contraindications for opioid agonists, opioid antagonists, and mixed agents; (Core)

4.6.b.9. systemic opioids, to include use of patient controlled-analgesic systems; (Core)

4.6.b.10. systemic opioids, to include post-procedure analgesic management in the patient with chronic pain and/or opioid-induced hyperalgesia; (Core)

4.6.b.11. psychological and psychiatric approaches to treatment, including cognitive-behavioral therapy, psychosocial therapies, and treatment of psychiatric illness; (Core)

4.6.b.12. prescription drug detoxification concepts; (Core)

4.6.b.13. functional and vocational rehabilitation; (Core)

4.6.b.14. surgical approaches; (Core)

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4.6.b.15. complementary and alternative treatments in pain management; (Core)
[See FAQ in Appendix]

4.6.b.16. treatments that comprise multidisciplinary cancer pain care; (Core)

4.6.b.17. strategies to integrate pain management into the treatment model; (Core)

4.6.b.18. hospice and multidimensional treatments that comprise palliative care; and, (Core)
[See FAQ in Appendix]

4.6.b.19. treatment of pain in pediatric patients. (Core)

4.6.c. Fellows must demonstrate competence in their knowledge of general topics, research, and ethics; including: (Core)

4.6.c.1. epidemiology of pain; (Core)

4.6.c.2. pain issues related to the patient's sex; (Core)

4.6.c.3. placebo response; (Core)

4.6.c.4. multidisciplinary pain medicine; (Core)

4.6.c.5. organization and management of a pain center; (Core)

4.6.c.6. utilization review and program evaluation; (Core)

4.6.c.7. designing, reporting, and interpreting clinical trials of treatment for pain; (Core)

4.6.c.8. ethical standards in pain management and research; and, (Core)

4.6.c.9. animal models of pain and ethics of animal experimentation. (Core)

4.6.d. Fellows must demonstrate competence in their knowledge of interventional pain treatment, including: (Core)

4.6.d.1. selection criteria for a broad range of interventions and an understanding of the indications and potential advantages and outcomes of these interventions; (Core)

4.6.d.2. airway management skills; (Core)

4.6.d.3. sedation/analgesia; (Core)

4.6.d.4. fluoroscopic imaging and radiation safety; (Core)

4.6.d.5. pharmacology of local anesthetics and other injectable medications, to include radiographic contrast agents and steroid preparations; (Core)

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4.6.d.5.a. This must include treatment of local anesthetic systemic toxicity. (Core)

4.6.d.6. trigger point injections; (Core)

4.6.d.7. peripheral and cranial nerve blocks and ablation; (Core)

4.6.d.8. spinal injections, to include the following epidural injections: interlaminar; transforaminal; nerve root sheath injections; and zygapophysial joint injections; (Core)

4.6.d.9. discography and intradiscal/percutaneous disc treatments; (Core)

4.6.d.10. joint and bursal injections, to include sacroiliac, hip, knee, and shoulder joint injections; (Core)

4.6.d.11. sympathetic ganglion blocks; (Core)

4.6.d.12. epidural and intrathecal medication management; (Core)

4.6.d.13. spinal cord stimulation; and, (Core)

4.6.d.14. intrathecal drug administration systems. (Core)

4.7. ACGME Competencies – 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)

4.8. ACGME Competencies – Interpersonal and Communication Skills
Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core)

4.9. ACGME Competencies – 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)

Curriculum Organization and Fellow Experiences

4.10. Curriculum Structure
The curriculum must be structured to optimize fellow educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)

4.10.a. Programs must provide each fellow with clinical experiences/rotations of sufficient duration and with sufficient continuity among supervising faculty that the progressive learning needed to support fellow development is not compromised. (Core)

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4.11. Didactic and Clinical Experiences

Fellows must be provided with protected time to participate in core didactic activities. (Core)

4.11.a. Each fellow must have a distinct clinical experience in the following disciplines involved in pain medicine: anesthesiology, child neurology or neurology, physical medicine and rehabilitation, and psychiatry. Fellows do not require an experience in their primary discipline. (Core)

4.11.a.1. Fellows must be provided with Outpatient (Continuity Clinic) Pain Experience. (Core)

[See FAQ in Appendix]

4.11.a.1.a. Pain medicine fellows should attend a supervised outpatient clinic at least one half-day weekly when averaged throughout the year. (Core)

> Subspecialty-Specific Background and Intent: Continuity experience will provide fellows with supervised experience in the ongoing management of a varied population of patients with chronic pain, including cancer pain. The experience allows interaction with other specialists in a multidisciplinary model of chronic pain management. This clinical experience may be interspersed and may be half-day experiences.

4.11.a.1.b. Fellows must have primary responsibility for 50 different patients followed over at least two months. (Core)

4.11.a.1.b.1. This experience should be documented. (Detail)

4.11.a.2. Fellows must be provided with Inpatient Chronic Pain Experience. (Core)

4.11.a.2.a. Inpatient chronic pain experience should include assessment and management of inpatients with chronic pain. Fellows should see patients through a consultation team or on a designated inpatient pain medicine service. (Detail)

4.11.a.2.a.1. This should include documented involvement with a minimum of 15 patients new to the fellow. (Detail)

4.11.a.3. Fellows must be provided with Acute Pain Inpatient Experience. (Core)

4.11.a.3.a. Acute pain inpatient experience should include supervised assessment and management of inpatients with acute pain. (Detail)

4.11.a.3.a.1. This should include documented involvement with a minimum of 50 patients new to the fellow. (Detail)

4.11.a.4. Fellows must be provided with Cancer Pain Experience. (Core)

[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]

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4.11.a.4.a. Cancer pain experience should be a supervised, longitudinal experience in an ambulatory or inpatient population that requires care for cancer pain, and may be integrated with continuity or inpatient experiences. (Detail)

4.11.a.5. Fellows must be provided with Palliative Care Experience. (Core)
[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]

4.11.a.5.a. Palliative care must be a supervised longitudinal experience in an ambulatory or inpatient population that requires palliative care, and may be integrated with continuity experience or inpatient experience. (Core)

4.11.b. The didactic curriculum must be prepared by the program director, who, together with the faculty, must ensure the curriculum complies with the written goals for the program. (Detail)

4.11.c. The didactic curriculum must be prepared by the program director, who, together with the faculty, must ensure pain medicine conferences are held at least monthly. (Detail)

4.11.c.1. This should include morbidity and mortality conferences, journal reviews, and research seminars. (Detail)

4.11.c.2. There should be active participation in the planning and presentation of these conferences by fellows and faculty members. (Detail)

4.12. Pain Management

The program must provide instruction and experience in pain management if applicable for the subspecialty, including recognition of the signs of substance use disorder. (Core)

Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through fellow participation in scholarly activities as defined in the subspecialty-specific Program Requirements. Scholarly activities may include discovery, integration, application, and teaching.

The ACGME recognizes the variety of fellowships and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.

4.13. Program Responsibilities

The program must demonstrate evidence of scholarly activities, consistent with its mission(s) and aims. (Core)

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4.13.a. **The program in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate fellow and faculty involvement in scholarly activities.** (Core)

4.14. **Faculty Scholarly Activity**

Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)

- **Research in basic science, education, translational science, patient care, or population health**
- **Peer-reviewed grants**
- **Quality improvement and/or patient safety initiatives**
- **Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports**
- **Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials**
- **Contribution to professional committees, educational organizations, or editorial boards**
- **Innovations in education**

4.14.a. **The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:**

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

4.14.a.1. **faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor;** (Outcome)

4.14.a.2. **peer-reviewed publication.** (Outcome)

4.15. **Fellow Scholarly Activity**

All fellows must complete a scholarly project. (Core)

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4.15.a. The results of such projects must be disseminated through a variety of means, including publication or presentation at local, regional, national, or international meetings. (Core)

Section 5: Evaluation

5.1. Fellow Evaluation: Feedback and Evaluation

Faculty members must directly observe, evaluate, and frequently provide feedback on fellow performance during each rotation or similar educational assignment. (Core)

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.

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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.

5.1.a. Evaluation must be documented at the completion of the assignment. (Core)

5.1.a.1. For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)

5.1.a.2. Longitudinal experiences such as continuity clinic in the context of other clinical responsibilities must be evaluated at least every three months and at completion. (Core)

5.1.b. The program must provide an objective performance evaluation based on the Competencies and the subspecialty-specific Milestones, and must: (Core)

5.1.b.1. use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)

5.1.b.2. provide that information to the Clinical Competency Committee for its synthesis of progressive fellow performance and improvement toward unsupervised practice. (Core)

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.

5.1.c. The program director or their designee, with input from the Clinical Competency Committee, must meet with and review with each fellow their documented semi-annual evaluation of performance, including progress along the subspecialty-specific Milestones. (Core)

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5.1.d. **The program director or their designee, with input from the Clinical Competency Committee, must assist fellows in developing individualized learning plans to capitalize on their strengths and identify areas for growth.** (Core)

5.1.e. **The program director or their designee, with input from the Clinical Competency Committee, must develop plans for fellows failing to progress, following institutional policies and procedures.** (Core)

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.

5.1.f. **At least annually, there must be a summative evaluation of each fellow that includes their readiness to progress to the next year of the program, if applicable.** (Core)

5.1.g. **The evaluations of a fellow's performance must be accessible for review by the fellow.** (Core)

5.1.h. Feedback on fellow performance should include evaluations of attitude, interpersonal relationship skills, fund of knowledge, manual skills, decision-making skills, and critical analysis of clinical situations. (Detail)

5.1.i. There must be periodic evaluation of patient care (quality assurance). (Detail)

5.2. Fellow Evaluation: Final Evaluation

The program director must provide a final evaluation for each fellow upon completion of the program. (Core)

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5.2.a. **The subspecialty-specific Milestones, and when applicable the subspecialty-specific Case Logs, must be used as tools to ensure fellows are able to engage in autonomous practice upon completion of the program. (Core)**

5.2.b. **The final evaluation must become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy. (Core)**

5.2.c. **The final evaluation must verify that the fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice. (Core)**

5.2.d. **The final evaluation must be shared with the fellow upon completion of the program. (Core)**

5.3. **Clinical Competency Committee**

A Clinical Competency Committee must be appointed by the program director. (Core)

[See FAQ in Appendix] [See FAQ in Appendix]

5.3.a. **At a minimum the Clinical Competency Committee must include three members, at least one of whom is a core faculty member. Members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows. (Core)**

Background and Intent: The requirements regarding the Clinical Competency Committee do not preclude or limit a program director's participation on the Clinical Competency Committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director's other roles as fellow advocate, advisor, and confidante; the impact of the program director's presence on the other Clinical Competency Committee members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for fellow evaluation and promotion decisions.

The program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's fellows. There may be additional members of the Clinical Competency Committee.

[See FAQ in Appendix] [See FAQ in Appendix]

5.3.b. **The Clinical Competency Committee must review all fellow evaluations at least semi-annually. (Core)**

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5.3.c. **The Clinical Competency Committee must determine each fellow's progress on achievement of the subspecialty-specific Milestones. (Core)**

5.3.d. **The Clinical Competency Committee must meet prior to the fellows' semi-annual evaluations and advise the program director regarding each fellow's progress. (Core)**

5.4. **Faculty Evaluation**

The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

Background and Intent: The program director is responsible for the educational program and for all educators. 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 varied 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.

5.4.a. **This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)**

5.4.b. **This evaluation must include written, confidential evaluations by the fellows. (Core)**

5.4.c. **Faculty members must receive feedback on their evaluations at least annually. (Core)**

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5.4.d. **Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans.** (Core)

Background and Intent: The quality of the faculty's teaching and clinical care is a determinant of the quality of the program and the quality of the fellows' future clinical care. Therefore, the program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. This section mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

5.5. **Program Evaluation and Improvement**

The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)

5.5.a. **The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one fellow.** (Core)

5.5.b. **Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them.** (Core)

5.5.c. **Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes.** (Core)

5.5.d. **Program Evaluation Committee responsibilities must include review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.** (Core)

Background and Intent: To achieve its mission and educate 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. The Program Evaluation Committee advises the program director through program oversight.

5.5.e. **The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate fellow and faculty written evaluations of the program, and other relevant data in its assessment of the program.** (Core)

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Background and Intent: Other data to be considered for assessment include:

- **Curriculum**
- **ACGME letters of notification, including citations, Areas for Improvement, and comments**
- **Quality and safety of patient care**
- **Aggregate fellow and faculty well-being; recruitment and retention; engagement in quality improvement and patient safety; and scholarly activity**
- **ACGME Fellow and Faculty Survey results**
- **Aggregate fellow Milestones evaluations, and achievement on in-training examinations (where applicable), board pass and certification rates, and graduate performance**
- **Aggregate faculty evaluation and professional development**

5.5.f. The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 5.5.f. has been suspended]

5.5.g. The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the fellows and the members of the teaching faculty, and be submitted to the DIO. (Core)

5.5.h. The program must participate in a Self-Study and submit it to the DIO. (Core)

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 5.5.h. has been suspended]

Board Certification

One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.

The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.

5.6. Board Certification

For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)

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5.6.a. **For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty.** **(Outcome)**

5.6.b. **For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty.** **(Outcome)**

5.6.c. **For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty.** **(Outcome)**

5.6.d. **For each of the exams referenced in 5.6. – 5.6.c., any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that subspecialty.** **(Outcome)**

Background and Intent: Setting a single standard for pass rate that works across subspecialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are subspecialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and 5.6.d. is designed to address this.

5.6.e. **Programs must report, in ADS, board certification status annually for the cohort of board-eligible fellows that graduated seven years earlier.** **(Core)**

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.

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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.

Section 6: The Learning and Working Environment

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***
- ***Appreciation for the privilege of providing care for patients***
- ***Commitment to the well-being of the students, residents, fellows, faculty members, and all members of the health care team***

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.

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

Patient Safety Events

Reporting, investigation, and follow-up of safety 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.

6.2. Residents, fellows, faculty members, and other clinical staff members must know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events. (Core)

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6.2.a. Residents, fellows, faculty members, and other clinical staff members must be provided with summary information of their institution's patient safety reports. (Core)

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

Quality Metrics

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

6.4. Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)

[See FAQ in Appendix]

Supervision and Accountability

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

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

6.5. Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to fellows, faculty members, other members of the health care team, and patients. (Core)

Background and Intent: Each patient will have an identifiable and appropriately credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care.

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

Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There

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is tremendous variability of fellow-patient interactions, 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. The level of supervision for each fellow is commensurate with that fellow's level of independence in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious safety events, or other pertinent variables.

[See FAQ in Appendix]

Levels of Supervision

To promote appropriate fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision.

6.7. Direct Supervision

The supervising physician is physically present with the fellow during the key portions of the patient interaction.

The supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

[See FAQ in Appendix]

Indirect Supervision

The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the fellow for guidance and is available to provide appropriate direct supervision.

Oversight

The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

6.8. The program must define when physical presence of a supervising physician is required. (Core)

[See FAQ in Appendix]

6.9. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. (Core)

6.9.a. The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones. (Core)

6.9.b. Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow. (Core)

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6.9.c. **Fellows should serve in a supervisory role to junior fellows and residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.** (Detail)

6.10. **Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s).** (Core)

6.10.a. **Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence.** (Outcome)

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

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

6.12. **Professionalism**

Programs, in partnership with their Sponsoring Institutions, must educate fellows and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

> **Background and Intent: This requirement emphasizes the professional responsibility of fellows and faculty members to arrive for work adequately rested and ready to care for patients. It is also the responsibility of fellows, faculty members, 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. This includes recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team, and the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested practitioner.**

6.12.a. **The learning objectives of the program must be accomplished without excessive reliance on fellows to fulfill non-physician obligations.** (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**

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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.

6.12.b. **The learning objectives of the program must ensure manageable patient care responsibilities.** (Core)

Background and Intent: The Common Program Requirements do not define "manageable patient care responsibilities" as this is variable by specialty/subspecialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty- and subspecialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty/subspecialty, should carefully assess how the assignment of patient care responsibilities can affect work compression.

6.12.c. **The learning objectives of the program must include efforts to enhance the meaning that each fellow finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships.** (Core)

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

Background and Intent: The accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data are the responsibility of the program leadership, fellows, and faculty.

[See FAQ in Appendix]

6.12.e. **Fellows and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events.** (Core)
[See FAQ in Appendix]

6.12.f. **Programs, in partnership with their Sponsoring Institutions, must provide a professional, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, fellows, faculty, and staff.** (Core)

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Background and Intent: Psychological safety is defined as an environment of trust and respect that allows individuals to feel able to ask for help, admit mistakes, raise concerns, suggest ideas, and challenge ways of working and the ideas of others on the team, including the ideas of those in authority, without fear of humiliation, and the knowledge that mistakes will be handled justly and fairly.

The ACGME is unable to adjudicate disputes between individuals, including residents, faculty members, and staff members. However, information that suggests a pattern of behavior that violates the requirement above will trigger a careful review and, if deemed appropriate, action by the Review Committee and/or ACGME, in accordance with ACGME Policies and Procedures.

6.12.g. Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

Well-Being

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

Fellows and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares fellows with the skills and attitudes needed to thrive throughout their careers.

6.13. The responsibility of the program, in partnership with the Sponsoring Institution, must include:

6.13.a. attention to scheduling, work intensity, and work compression that impacts fellow well-being; (Core)

6.13.b. 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 informa-

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tion 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 safety events.

6.13.c. **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. 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.

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

6.13.d. **education of fellows and faculty members in:**

6.13.d.1. **identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)**
[See FAQ in Appendix]

6.13.d.2. **recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)**

6.13.d.3. **access to appropriate tools for self-screening. (Core)**

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

Individuals experiencing burnout, depression, a substance use disorder, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions and may be 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

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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/well-being programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

6.13.e. **providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)**

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.

6.14. **There are circumstances in which fellows may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for fellows unable to perform their patient care responsibilities. (Core)**

6.14.a. **The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)**

6.14.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 fairly reintegrate them upon return.

6.15. **Fatigue Mitigation**

Programs must educate all fellows and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)

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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.

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.

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

6.17. Clinical Responsibilities

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

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on fellows. Faculty members and program directors need to make sure fellows function in an environment that has safe patient care and a sense of fellow well-being. 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.

6.17.a. An optimal clinical workload allows fellows to complete the required case numbers and develop the required competencies in patient care with a focus on learning over meeting service obligations. (Detail)

6.18. Teamwork

Fellows must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the subspecialty and larger health system. (Core)

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Background and Intent: Effective programs will have a structure that promotes safe, interprofessional, team-based care. Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

[See FAQ in Appendix]

6.19. Transitions of Care

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

[See FAQ in Appendix]

6.19.a. Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)

6.19.b. Programs must ensure that fellows are competent in communicating with team members in the hand-off process. (Outcome)

Clinical Experience and Education

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

Background and Intent: 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 terms are used 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.

6.20. Maximum Hours of Clinical and Educational Work per Week

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

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.

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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 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.

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.

[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]

6.21. Mandatory Time Free of Clinical Work and Education

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

Background and Intent: There may be circumstances when fellows choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This occurs within the context of the 80-hour and the one-day-off-in-seven requirements. 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

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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.

6.21.a. Fellows must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)

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.

[See FAQ in Appendix]

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

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."

[See FAQ in Appendix]

6.22. Maximum Clinical Work and Education Period Length

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

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

Background and Intent: The additional time referenced in 6.22.a. 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.

[See FAQ in Appendix]

6.23. Clinical and Educational Work Hour Exceptions

In rare circumstances, after handing off all other responsibilities, a fellow, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)

6.23.a. These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)

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.

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

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

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 6.24. has been suspended]

6.25. Moonlighting

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

[See FAQ in Appendix]

6.25.a. **Time spent by fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.** (Core)

6.26. **In-House Night Float**

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

6.27. **Maximum In-House On-Call Frequency**

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

6.28. **At-Home Call**

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

[See FAQ in Appendix] [See FAQ in Appendix]

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

Background and Intent: As noted in 6.20., clinical work done from home when a fellow is taking at-home call must count toward the 80-hour maximum weekly limit. This 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.

[See FAQ in Appendix]

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7. Frequently Asked Questions: Pain Medicine

FAQs related to Pain Medicine Program Requirements

Last updated July 2026

Review Committees for Anesthesiology, Neurology, and Physical Medicine and Rehabilitation

Section 1: Oversight

Questions concerning *"There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)"* (1.3)

Q: What is the purpose of program letters of agreement (PLAs)?

A: PLAs provide details on faculty members, supervision, evaluation, educational content, length of assignment, and policies and procedures for each required assignment that occurs outside of an accredited program's Sponsoring Institution. These documents are intended to protect the program's residents/fellows by ensuring an appropriate educational experience under adequate supervision.

Questions concerning *"There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)"* (1.3)

Q: Under what circumstances are PLAs required?

A: There must be PLAs between an accredited program and all participating sites to which residents/fellows rotate for required education or assignments. PLAs are not required for participating sites under the same governance as the program's Sponsoring Institution. PLAs are not required for elective rotations for individual residents and fellows, but programs and Sponsoring Institutions may determine if there are local expectations for a PLA or similar agreement.

Questions concerning *"There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)"* (1.3)

Q: Are PLAs necessary for "courses," such as the Armed Forces Institute of Pathology course or the Bellevue Hospital Toxicology Course?

A: These types of courses are not examples of participating sites, and therefore do not require PLAs.

Questions concerning *"There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)"* (1.3)

Q: Who should sign the PLAs?

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A: It is the responsibility of the designated institutional official (DIO), in collaboration with the Graduate Medical Education Committee (GMEC) of the Sponsoring Institution, to establish and administer the local policies and procedures regarding PLAs and determine the individuals authorized to sign the PLAs.

Section 2: Personnel

Questions concerning *"Qualifications of the Program Director"* (2.4) , *"The program director must possess current certification in the subspecialty for which they are the program director by the American Board of Anesthesiology, Physical Medicine and Rehabilitation, or Psychiatry and Neurology, the American Osteopathic Board of Anesthesiology, or a member board of the American Osteopathic Conjoint Pain Medicine Examination Committee, or subspecialty qualifications that are acceptable to the Review Committee. (Core)"* (2.4.a)

Q: Are there circumstances in which a Sponsoring Institution, in partnership with its programs, is required to provide support and dedicated time that exceeds the minimum specified in the requirements?

A: The dedicated time and support requirements for ACGME activities specified in 2.4. and 2.4.a. for program leadership, 2.12.a. and 2.12.b. for program coordinators, and section 2.11. for those specialties that specify a minimum level of support for core faculty members, are minimum requirements, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program director, is also addressed in Institutional Requirements 2.2.-2.2.d. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty-/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program directors, core faculty members, and program coordinators to fulfill their program responsibilities effectively. If the Institutional Review Committee determines that support and dedicated time for one or more programs within a Sponsoring Institution is inadequate, it may issue a citation even if the minimum specified in the applicable specialty-/subspecialty-specific Program Requirements has been met.

Note that Review Committees may choose to specify minimum time and support for the program director only, or may specify minimum time and support that may be divided among the program director and one or more associate or assistant program directors. Questions regarding the requirements for a specific specialty should be directed to the Review Committee Executive Director.

Questions concerning *"Any other specialty or subspecialty physician faculty members must have current certification in their specialty or subspecialty 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) "* (2.9.a)

Q: Would a clinical psychologist with a doctorate (PhD) be accepted as qualified psychiatry faculty?

A: Each program will be evaluated on a case-by-case basis. Programs are encouraged to establish meaningful educational relationships with a physician trained in psychiatry. How-

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ever, it is recognized that a clinical psychologist may contribute in a meaningful way to the program.

Section 3: Fellow Appointments

Questions concerning *"Eligibility Requirements – Fellowship Programs"* (3.2)

Q: Are individuals who have completed a combined residency program not accredited by the ACGME eligible for appointment to an ACGME-accredited fellowship program?

A: Effective July 1, 2025, the ACGME accredits combined programs. If each of the programs participating in the combined format was ACGME-accredited prior to July 1, 2025, residents enrolled in the combined program are eligible for transfer into another ACGME-accredited residency program and graduates of the program are eligible for appointment to an ACGME-accredited fellowship.

Questions concerning *" review and approval of the applicant's exceptional qualifications by the GMEC; and, (Core) "* (3.2.b.1.b)

Q: Why does the ACGME require the GMEC or a subcommittee of the GMEC to review and approve all candidates under the "exceptionally qualified applicant" exception?

A: The Review Committee sets the requirements, and the program determines if a candidate meets the stated criteria. Because the Review Committee does not review or approve the determination of an exceptionally qualified applicant, the ACGME relies on the Sponsoring Institution to provide oversight in the selection of exceptional candidates and monitoring of their performance. The oversight need not be burdensome or intrusive; rather it provides an opportunity for the GMEC to collaborate with programs to ensure that these select candidates fulfill expectations for entry-level competence.

Section 4: Educational Program

Questions concerning *"ACGME Competencies – Patient Care and Procedural Skills (Part A)"* (4.4)

Q: How should programs maintain documentation of numbers of patients in each required category, and how much detail should be included in the documentation?

A: Programs should develop a system for fellows to record patient encounters as specified in the Program Requirements. Ultimately, each fellow is responsible for maintaining adequate records that document all the required experiences. The program director, however, should counsel all fellows at the start of their fellowships regarding the need for this record-keeping, suggest a method for keeping these records, and periodically review these patient logs to ensure that they remain up to date and accurate. Reliance on average patient volume from clinic or hospital billing records will NOT be considered adequate documentation of individual fellow experience. The intent of this requirement is to document the *actual* number of patients seen by *each* fellow. The documentation is to support that each fellow gains *at least* the minimal clinical exposure specified in the clinical components of the Program Requirements.

Questions concerning *"ACGME Competencies – Patient Care and Procedural Skills (Part A)"* (4.4)

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Q: What constitutes an adequate curriculum for each of the subspecialty components of a pain medicine fellowship?

A: To meet the clinical experience requirements in anesthesiology, neurology, physical medicine and rehabilitation, and psychiatry, a program must demonstrate that each fellow is provided the educational experiences specified in the Program Requirements, and describe how these clinical experiences will allow fellows to develop the skills required for each of those specialty components of pain medicine education.

Program directors are also referred to the International Association for the Study of Pain (IASP) Interprofessional Pain Curriculum Outline, available at http://www.iasp-pain.org, for additional information on areas of didactic instruction and educational experience listed in the Program Requirements for Graduate Medical Education in Pain Medicine.

Questions concerning *"Neuro-imaging study training must be verified by a faculty member from an ACGME-accredited residency program in child neurology/neurology, neurological surgery, or radiology, or by a faculty member with qualifications acceptable to the Review Committee. (Detail) "* (4.4.c.3)

Q: Do fellows have to rotate to a radiology department to read films and have direct supervision by a qualified radiology faculty member?

A: No. Pain medicine fellows may gain their radiology experience through the routine use of imaging in the diagnosis and treatment in the course of direct patient care. Any physician who has demonstrated expertise in the interpretation of imaging studies may provide this aspect of the educational program. Programs are encouraged to include radiologists in the educational program of pain medicine fellowships.

Questions concerning *"This must include experience with laryngeal mask airway and/or endotracheal intubation as a back-up if mask ventilation is unsuccessful. (Core) "* (4.5.c.1)

Q: Is experience with laryngeal mask airway and/or endotracheal intubation acquired on a simulator or mannequin acceptable to meet all or part of the anesthesiology experience for non-anesthesiologists in pain medicine programs?

A: No. Pain medicine fellows must gain their anesthesiology experience through direct care of patients in the operating room environment.

Questions concerning *"Fellows must demonstrate competence in basic life support and advanced cardiac life support. (Core) "* (4.5.d)

Q: Is certification in basic and advanced cardiac life support required for all pain medicine fellows?

A: Yes. The intent of this requirement is that all pain medicine fellows will receive education and achieve certification in basic and advanced cardiac life support during the 12-month fellowship.

Questions concerning *"cancer pain, including palliative and hospice care; (Core) "* (4.6.a.16) , *"complementary and alternative treatments in pain management; (Core) "* (4.6.b.15) , *"hospice and multidimensional treatments that comprise palliative care; and, (Core) "* (4.6.b.18)

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Q: How should patients receiving palliative care and cancer pain patients be distinguished from each other, and can there be overlap as far as fulfilling the requirements related to palliative care?

A: Palliative care and cancer pain patients may be mutually exclusive or there may be significant overlap, in that patients with a cancer diagnosis are being cured of their tumors with increasing frequency. The intent of the palliative care requirement is to expose fellows to the assessment and management of pain and other distressing symptoms in patients where curative treatment is no longer the primary goal.

Questions concerning *"Fellows must be provided with Outpatient (Continuity Clinic) Pain Experience. (Core) "* (4.11.a.1)

Q: Is it expected that fellows will have primary responsibility for patients in the continuity care clinic?

A: The exact means by which fellows gain longitudinal experience will vary from one program to another. It is understood that optimal patient care requires the direct involvement of the supervising physician and often mandates that one attending physician retains primary responsibility for each patient. However, the structure of the educational program must allow for each fellow to gain repeated exposure to a significant number of patients during the fellowship and provide a mechanism for documenting this experience.

Questions concerning *"Fellows must be provided with Cancer Pain Experience. (Core)"* (4.11.a.4)

Q: Are there any requirements for supervision of fellows by oncology faculty members for the required cancer pain experience?

A: There is no requirement that oncology faculty members be directly involved in a fellow's cancer pain experience during the pain medicine fellowship. The ongoing involvement of oncologists in the educational program is encouraged.

Questions concerning *"Fellows must be provided with Cancer Pain Experience. (Core)"* (4.11.a.4) , *"Fellows must be provided with Palliative Care Experience. (Core)"* (4.11.a.5)

Q: How is 'longitudinal' involvement in patient care defined?

A: Longitudinal involvement in patient care means repeated interaction with the same patient over the course of the assessment and treatment of their painful condition. The fellow should see patients on two or more occasions. Longitudinal experience over brief intervals (e.g., several days in hospitalized patients; a single follow-up interaction in the outpatient setting) should not serve as the sole longitudinal experience for fellows. Rather, fellows must be provided with the opportunity to see patients repeatedly over the course of the fellowship year. This experience is essential for fellows to understand the usual course of common pain conditions and the expected results of the treatments they deliver.

Questions concerning *"Fellows must be provided with Cancer Pain Experience. (Core)"* (4.11.a.4) , *"Fellows must be provided with Palliative Care Experience. (Core)"* (4.11.a.5)

Q: How should fellows document a longitudinal experience?

A: Documentation of all data, including numbers and dates of patient encounters, should be maintained. It is recommended that programs maintain these procedure logs in each fellow's portfolio.

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Questions concerning *"Fellows must be provided with Cancer Pain Experience. (Core)"* (4.11.a.4) , *"Fellows must be provided with Palliative Care Experience. (Core)"* (4.11.a.5)

Q: How do the requirements for the longitudinal experience apply to fellows who are assigned for a period of six months at one institution, and for three months each at two other participating sites?

A: Fellows must be provided with the opportunity to see the required number of patients repeatedly over the course of the fellowship year, regardless of how their time is split among institutions for assignments.

Questions concerning *"Fellows must be provided with Palliative Care Experience. (Core)"* (4.11.a.5)

Q: How is palliative care defined and how is it distinguished from hospice care?

A: In contrast to curative treatment, palliative care is defined as the care of all patients for whom the relief of pain and suffering associated with illness is the primary goal of treatment. As such, many of these patients are likely to be nearing the end of life. A subset of patients receiving palliative care is likely to be cared for in a formal hospice program. A hospice program is defined as *a structured program in the inpatient or outpatient setting focused on relieving the suffering of patients as they near the end of life*.

Section 5: Evaluation

Questions concerning *"Clinical Competency Committee"* (5.3)

Q: What is the role of the program director on the Clinical Competency Committee (CCC)?

A: The requirements regarding the CCC do not preclude or limit a program director's participation on the committee, however, programs should consult with Review Committee staff for any specialty or subspecialty-specific guidance. The intent is to leave flexibility for each program to decide the best structure for its own circumstances. Still, a program should consider: its program director's other roles as resident/fellow advocate, advisor, and confidante; the impact of the program director's presence on the other CCC members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for the program's evaluation and promotion decisions.

Questions concerning *"Clinical Competency Committee"* (5.3)

Q: What is the role of the program coordinator on the CCC?

A: Program coordinators play a critical role in their programs and may, through the program's resident/fellow evaluation system, provide valuable insight on resident/fellow performance in areas such as interpersonal and communication skills, teamwork, and professionalism. Further, the program coordinator may, at the program director's discretion, attend CCC meetings to support the activities of the CCC, such as collation of data on each resident/fellow, taking meeting minutes, recording decisions, and managing the submission of Milestones data to the ACGME. However, evaluation of resident/fellow competence related to the Milestones for patient care and medical knowledge is a vital responsibility of the CCC and these assessments should be made by individuals with background and experience in health care. Therefore, program coordinators, although they may administratively support

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the committee and take part in the 360 assessments of the residents/fellows, may not serve as voting members of the CCC.

Questions concerning *"At a minimum the Clinical Competency Committee must include three members, at least one of whom is a core faculty member. Members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows. (Core)"* (5.3.a)

Q: How can small programs have three program faculty members on the CCC?
A: The intent is to have enough members to broaden the input on each resident's/fellow's evaluation. Program faculty representation can include more than physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents/fellows. For example, a fellowship may include faculty members from the affiliated residency program or from required rotations in other specialties.

Questions concerning *"At a minimum the Clinical Competency Committee must include three members, at least one of whom is a core faculty member. Members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows. (Core)"* (5.3.a)

Q: What role can program residents, including chief residents who have not completed the program, play on the CCC?
A: Program residents and chief residents in accredited years of the program may provide input to the CCC Chair and/or the program director, outside the context of CCC meetings, through the evaluation system. However, to ensure that residents' peers are not involved in promotion and graduation decisions, and that they are not involved in recommendations for remediation or disciplinary actions, these residents may not serve as CCC members or attend CCC meetings.

Section 6: The Learning and Working Environment

Questions concerning *"Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)"* (6.4)

Q: With regards to the requirement relating to provision of data to residents/fellows and faculty members on quality metrics and benchmarks related to their patient populations, is the expectation that individual data regarding clinical performance must be provided?
A: Providing individual, specialty-specific data is desirable, but not required. The requirement seeks to ensure that quality metrics used by the Sponsoring Institution are shared with residents/fellows and faculty members. Examples of metrics include, but are not limited to, those provided by the Hospital Consumer Assessment of Healthcare Providers and Systems, Centers for Medicaid and Medicare Services, Press Gainey, and National Surgical Quality Improvement Program.

Questions concerning *"The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)"* (6.6) , *"Direct Supervision"* (6.7) , *"The program must define when physical presence of a supervising physician is required. (Core)"* (6.8)

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Q: How should the appropriate level of supervision be determined for each resident or fellow?

A: The assignment of progressive responsibility for patient care to residents and fellows is an essential component of graduate medical education and is necessary to prepare residents and fellows to be independent practitioners. While decisions regarding the appropriate level of supervision are made by the program director in consultation with the CCC, the Common Program Requirements provide a framework for the progression from direct supervision to oversight. The program director determines the level of supervision required for an individual resident or fellow both by assessing the abilities and competence of the resident/fellow and the needs of the individual patient. Therefore, the level of supervision required for a resident or fellow may vary based on the circumstances.

Questions concerning *" The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core) "* (6.12.d) , *" Fellows and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core) "* (6.12.e) , *"Moonlighting"* (6.25)

Q: In addition to the 80-hour maximum weekly limit, do all other clinical and educational work hour rules apply to moonlighting (maximum clinical and educational work period length, minimum time off between shifts, etc.)?

A: The hours spent moonlighting are counted toward the total hours worked for the week. No other clinical and educational work hour requirements apply, but the following requirements do:

- 6.25 “Moonlighting must not interfere with the ability of the resident/fellow to achieve the goals and objectives of the educational program, and must not interfere with the resident’s/fellow’s fitness for work nor compromise patient safety.”
- 6.12.d.-6.12.e.“The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. Residents/Fellows and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events.”

Questions concerning *"identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)"* (6.13.d.1)

Q: Can residents/fellows be required to use vacation or sick time when attending appointments during scheduled working hours?

A: The requirements do not specify whether residents/fellows will be required to use vacation or sick time for medical, dental, and mental health appointments. Programs should comply with their institution’s policies regarding time off for such appointments.

The intent of this requirement is to ensure that residents and fellows are able to attend appointments as needed, and that their work schedule not prevent them from seeking care when they need it, including during scheduled call days.

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Questions concerning *"Teamwork"* (6.18)

Q: Who should be part of the interprofessional teams?

A: Contributors to effective interprofessional teams in pain medicine may include consulting physicians, psychologists, psychiatric nurses, social workers and other professional and paraprofessional mental health personnel involved in the treatment of patients.

Questions concerning *"Transitions of Care"* (6.19)

Q: What are the ACGME's expectations regarding transitions of care, and how should programs and institutions monitor effective transitions of care and minimize the number of such transitions?

A: Transitions of care are critical elements in patient safety and must be organized such that complete and accurate clinical information on all involved patients is transmitted between the outgoing and incoming individuals and/or teams responsible for the specific patient or group of patients. Sponsoring Institutions and programs are expected to have a documented process in place for ensuring the effectiveness of transitions. Scheduling of on-call assignments should be optimized to ensure a minimal number of transitions, and there should be documentation of the process involved in arriving at the final schedule. Specific schedules will depend upon various factors, including the size of the program, the acuity and quantity of the workload, and the level of resident/fellow education.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: What are the ACGME's expectations regarding monitoring of clinical and educational work hours for all accredited programs?

A: The ACGME requires that Sponsoring Institutions and programs monitor residents'/fellows' clinical and educational work hours, including work done from home (as applicable), to ensure they comply with the requirements, but does not specify how monitoring and tracking of clinical and educational work hours should be accomplished. The ACGME does not mandate a specific monitoring approach since the ideal approach should be tailored to each program and its Sponsoring Institution.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: Do the ACGME Common Program Requirements related to clinical and educational work hours apply to research activities?

A: The clinical and educational work hour requirements pertain to all required hours in the program (the only exceptions are reading and self-learning). When research is a formal part of the residency/fellowship and occurs during the accredited years of the program, research hours or any combination of research and patient care activities must comply with the weekly limit on hours and other pertinent clinical and educational work hour requirements.

When programs offer an additional research year that is not part of the accredited years, or when residents/fellows conduct research on their own time, making these hours identical to other personal pursuits, these hours do not count toward the limit on clinical and educational work hours. The combined hours spent on self-directed research and program-required activities should meet the test for a reasonably rested and alert resident/fellow when the resident/fellow participates in patient care.

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Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: What is included in the definition of clinical and educational work hours under the requirement limiting them to 80 hours per week?

A: Clinical and educational work hours are defined as all clinical and academic activities related to the residency/fellowship program. This includes inpatient and outpatient clinical care, in-house call, short call, night float and day float, transfer of patient care, and administrative activities related to patient care, such as completing medical records, ordering and reviewing lab tests, and signing orders. For call from home, time devoted to clinical work done from home and time spent in the hospital after being called in to provide patient care count toward the 80-hour weekly limit. Types of work from home that must be counted include using an electronic health record and taking calls. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours.

Hours spent on activities that are required in the accreditation requirements, such as membership on a hospital committee, or that are accepted practice in residency/fellowship programs, such as residents'/fellows' participation in interviewing residency/fellowship candidates, must be included in the count of clinical and educational work hours.

Time residents and fellows devote to military commitments counts toward the 80-hour limit only if that time is spent providing patient care.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: If some of a program's residents/fellows attend a conference that requires travel, how should the hours be counted for clinical and educational work hour compliance?

A: If attendance at the conference is required by the program, or if the resident/fellow is a representative for the program (e.g., presenting a paper or poster), the hours should be included as clinical and educational work hours. Travel time and non-conference hours while away do not meet the definition of "clinical and educational work hours" in the ACGME requirements.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: Why do the requirements specify that clinical work done from home must count toward the 80-hour weekly maximum, averaged over four weeks?

A: The requirements acknowledge the changes in medicine, including electronic health records, and the increase in the amount of work residents and fellows choose to do from home. Resident/Fellow decisions to complete work at home should be made in consultation with the resident's/fellow's supervisor. In such circumstances, residents/fellows should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality. The requirement provides flexibility for residents/fellows to do this while ensuring that the time spent completing clinical work from home is accomplished within the 80-hour weekly maximum.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

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Q: How should the averaging of the clinical and educational work hour requirements (e.g., 80-hour weekly limit, one day free of clinical and educational work every week, and call no more frequently than every third night) be handled? For example, what should be done if a resident/fellow takes a vacation week?

A: Averaging must occur by rotation. This is done over one of the following: a four-week period; a one-month period (28-31 days); or the period of the rotation if it is shorter than four weeks. When rotations are shorter than four weeks in length, averaging must be made over these shorter assignments. This avoids heavy and light assignments being combined to achieve compliance.

If a resident/fellow takes vacation or other leave, the ACGME requires that vacation or leave days be omitted from the numerator and the denominator for calculating clinical and educational work hours, call frequency, or days off. The requirements do not permit a "rolling" average, because this may mask compliance problems by averaging across high and low clinical and educational work hour rotations. The rotation with the greatest hours and frequency of call must comply with the common clinical and educational work hour requirements.

Questions concerning *" Fellows must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core) "* (6.21.a)

Q: If a post-call resident/fellow remains on site for up to four additional hours as described in the requirements, does the required 14-hour time-off period begin at the end of the scheduled 24-hour period, or when the resident/fellow leaves the hospital?

A: The 14-hour time-off period begins when the resident/fellow completes all required clinical and educational work, regardless of when the resident/fellow was scheduled to leave.

Questions concerning *" Fellows must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core) "* (6.21.b)

Q: Since the requirements state that residents/fellows must be provided with one day in seven free from all responsibilities, with one day defined as one continuous 24-hour period, how should programs interpret this requirement if the "day off" occurs after a resident's/fellow's on-call day?

A: The requirements specify a 24-hour day off. This day should ideally be a calendar day (i.e., the resident/fellow wakes up at home and has a whole day available). It is not permissible to have the day off regularly or frequently scheduled on a resident's/fellow's post-call day, but in smaller programs this may occasionally be necessary. Note that in this case, a resident/fellow would need to leave the hospital post-call early enough to allow for 24 hours off from clinical and educational work. Because call from home does not require a rest period, the day after home call may be used as a day off.

Questions concerning *" Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or fellow education. Additional patient care responsibilities must not be assigned to a fellow during this time. (Core) "* (6.22.a)

Q: What activities are permitted during the four hours allowed for activities related to patient safety and/or resident/fellow education?

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A: Residents/fellows who have completed a 24-hour clinical and educational work period may spend up to an additional four hours on site to ensure an appropriate, effective, and safe transition of care (including rounds), to maintain continuity of patient care, and to participate in educational activities such as conferences. During this four-hour period, residents/fellows must not be permitted to participate in the care of new patients in any patient care setting; must not be assigned to outpatient clinics, including continuity clinics; and must not be assigned to participate in a new procedure, such as an elective scheduled surgery. Residents/fellows who have satisfactorily completed the transition of care may attend an educational conference that occurs during this four-hour period.

Questions concerning *"At-Home Call"* (6.28)

Q: Is it permissible for residents/fellows to take call from home for extended periods, such as a month?

A: No. The requirement for one day free every week prohibits being assigned home call for an entire month. Assignment of a partial month (more than six days but fewer than 28 days) is possible. However, keep in mind that call from home is appropriate if service intensity and frequency of being called is low. Program directors are expected to monitor the intensity and workload resulting from home call through periodic assessment of workload and intensity of in-house activities.

Questions concerning *"At-Home Call"* (6.28) , *" At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow. (Core) "* (6.28.a)

Q: Which requirements apply to time in the hospital after being called in from home call?

A: For call taken from home (home or pager call), the time a resident/fellow spends in the hospital after being called in counts toward the weekly clinical and educational work hour limit. The only other numeric clinical and educational work hour requirement that applies is the one day free of clinical and educational work every week that must be free of all patient care responsibilities, which includes at-home call. Program directors must monitor the intensity and workload resulting from at-home call through periodic assessment of the frequency of being called into the hospital, and the length and intensity of the in-house activities.

When residents/fellows assigned to at-home call return to the hospital to care for patients, a new time-off period is not initiated, and therefore the requirement for eight hours between shifts does not apply. The frequency and duration of clinical work done from home and time returning to the hospital must not preclude rest or reasonable personal time for residents/fellows.

Other

Q: What does the Review Committee require of a fellow taking approved medical, parental, or caregiver leave(s) of absence?

[FAQ: Institutional Requirement: 4.8.]

A: The Review Committee allows for flexibility in approved leaves of absence at the program level, provided that all clinical and procedural experience requirements are met, and that the

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Clinical Competency Committee considers the affected fellow fully prepared for autonomous practice. The program director is also encouraged to seek guidance from the applicable specialty certifying board to ensure there will be no adverse effects on the fellow's board eligibility and ultimate board certification.

Q: Can the clinical and educational work hour requirements be relaxed over holidays or during other times when a hospital is short-staffed, during periods when some residents/fellows are ill or on leave, or when there is an unusually large patient census or demand for care?

A: The ACGME expects that clinical and educational work hours in any given four-week period comply with all applicable requirements. This includes months with holidays, during which institutions may have fewer staff members available. During the holiday period, scheduling for the rotation (generally four weeks or a month) must comply with the common and specialty-specific clinical and educational work hour requirements. Further, the schedule during the holidays themselves may not violate common clinical and educational work hour requirements (such as the requirement for adequate rest between clinical and educational work periods), or specialty-specific requirements.

Q: Where are the ACGME Resident/Fellow and Faculty Survey -Common Program Requirements Crosswalk documents located?

A: The crosswalk documents for the Resident/Fellow and Faculty Surveys can be found on the ACGME website here. These resources help programs, residents, fellows, and faculty understand and interpret their ACGME Resident/Fellow and Faculty Survey results by mapping ACGME survey questions to the corresponding Common Program Requirements.

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