

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

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48
49 The body of knowledge and practice of neuroradiology comprises both imaging
50 (computed tomography (CT), magnetic resonance imaging (MRI), plain film
51 interpretation, neurosonography, and nuclear radiology) and invasive procedures
52 related to the brain, spine and spinal cord, head, neck, and organs of special
53 sense (eyes, ears, nose) in adults and children. Neuroradiologists interpret
54 imaging findings based on their knowledge of the fundamentals of pathology,
55 pathophysiology, and clinical manifestations of the brain, spine and spinal cord,
56 head, neck, and organs of special sense.

57
58 The program provides fellows with the opportunity to develop, under supervision,
59 progressively independent skills in the performance and interpretation of
60 neuroradiologic imaging studies and invasive procedures. At the end of the
61 program, fellows should be capable of independent and accurate clinical
62 decision-making in all areas of neuroradiology.

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

65
66 The educational program in neuroradiology must be 12 months in length. (Core)*

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68 **I. Oversight**

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70 **I.A. Sponsoring Institution**

71
72 *The Sponsoring Institution is the organization or entity that assumes the*
73 *ultimate financial and academic responsibility for a program of graduate*
74 *medical education consistent with the ACGME Institutional Requirements.*

75
76 *When the Sponsoring Institution is not a rotation site for the program, the*
77 *most commonly utilized site of clinical activity for the program is the*
78 *primary clinical site.*

79
80 **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.**

81 **I.A.1. The program must be sponsored by one ACGME-accredited**
82 **Sponsoring Institution. (Core)**

83
84 **I.B. Participating Sites**

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

88

- 89 **I.B.1. The program, with approval of its Sponsoring Institution, must**
90 **designate a primary clinical site.** ^(Core)
91
- 92 I.B.1.a) The Sponsoring Institution should also sponsor an ACGME-
93 accredited residency program in diagnostic radiology. ^(Core)
94
- 95 I.B.1.a).(1) There must be a collaborative relationship between the
96 fellowship and residency program directors to ensure
97 optimal educational experiences for both residents and
98 fellows. ^(Core)
99
- 100 **I.B.2. There must be a program letter of agreement (PLA) between the**
101 **program and each participating site that governs the relationship**
102 **between the program and the participating site providing a required**
103 **assignment.** ^(Core)
104
- 105 I.B.2.a) The PLA must:
106
- 107 I.B.2.a).(1) be renewed at least every 10 years; and, ^(Core)
108
- 109 I.B.2.a).(2) be approved by the designated institutional official
110 (DIO). ^(Core)
111
- 112 **I.B.3. The program must monitor the clinical learning and working**
113 **environment at all participating sites.** ^(Core)
114
- 115 I.B.3.a) At each participating site there must be one faculty member,
116 designated by the program director, who is accountable for
117 fellow education for that site, in collaboration with the
118 program director. ^(Core)
119

Background and Intent: While all fellowship programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must designate a faculty member responsible for ensuring the quality of the educational experience. In some circumstances, the person charged with this responsibility may not be physically present at the site, but remains responsible for fellow education occurring at the site. The requirements under I.B.3. are intended to ensure that this will be the case.

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

- **Identifying the faculty members who will assume educational and supervisory responsibility for fellows**
- **Specifying the responsibilities for teaching, supervision, and formal evaluation of fellows**
- **Specifying the duration and content of the educational experience**

- **Stating the policies and procedures that will govern fellow education during the assignment**

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

I.C. The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents (if present), fellows, faculty members, senior administrative staff members, and other relevant members of its academic community. ^(Core)

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution’s mission and aims. The program’s annual evaluation must include an assessment of the program’s efforts to recruit and retain a diverse workforce, as noted in V.C.1.c).(5).(c).

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I.D. Resources

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

I.D.1.a) All related equipment required for advanced neuroimaging must be state-of-the-art and available. ^(Core)

I.D.1.b) Adequate space for image display, interpretation of studies, and consultation with clinicians must be available. ^(Core)

I.D.1.c) There must be adequate office space for neuroradiology faculty members, program administration, and fellows. ^(Core)

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

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

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

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that fellows function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities.

Access to food and rest are examples of these basic needs, which must be met while fellows are working. Fellows should have access to refrigeration where food may be stored. Food should be available when fellows are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued fellow.

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

Background and Intent: Sites must provide private and clean locations where fellows may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the fellow with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the fellow and the fellow's family, as outlined in VI.C.1.d).(1).

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- I.D.2.d) security and safety measures appropriate to the participating site; and, (Core)**

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

- I.D.3. 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)**

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

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

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

- I.E.1.a) The presence of other learners, and health care professionals, including residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners, must not interfere with the appointed fellows' education. (Core)**

- I.E.1.b) The fellows must not dilute or detract from the educational opportunities available to residents in the core diagnostic radiology residency program. (Core)**

Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and

fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that fellows' education is not compromised by the presence of other providers and learners, and that fellows' education does not compromise core residents' education.

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II. Personnel

II.A. Program Director

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

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

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

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

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

II.A.2.a) At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program: ^(Core)

Number of Approved Fellow Positions	Minimum Support Required (FTE)
<u>1-6</u>	0.1
<u>7-8</u>	0.2
<u>9 or more</u>	0.3

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

225

Number of Approved Fellow Positions	
1-4	227
5-7	228
8 or more	

229

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

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

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

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

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

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

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

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II.A.3.c) must include at least three years' experience as a faculty member in an ACGME-accredited diagnostic radiology residency or neuroradiology fellowship program; and, ^(Core)

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II.A.3.d) should include at least 80 percent of his or her time spent in the practice of neuroradiology. ^(Core)

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II.A.4. Program Director Responsibilities

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252 The program director must have responsibility, authority, and
253 accountability for: administration and operations; teaching and
254 scholarly activity; fellow recruitment and selection, evaluation, and
255 promotion of fellows, and disciplinary action; supervision of fellows;
256 and fellow education in the context of patient care. ^(Core)
257

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

259 **II.A.4.a).(1) be a role model of professionalism;** ^(Core)
260
261

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.

262
263 **II.A.4.a).(2) design and conduct the program in a fashion**
264 **consistent with the needs of the community, the**
265 **mission(s) of the Sponsoring Institution, and the**
266 **mission(s) of the program;** ^(Core)
267

Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and health disparities.

268
269 **II.A.4.a).(3) administer and maintain a learning environment**
270 **conducive to educating the fellows in each of the**
271 **ACGME Competency domains;** ^(Core)
272

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.

273
274 **II.A.4.a).(4) develop and oversee a process to evaluate candidates**
275 **prior to approval as program faculty members for**
276 **participation in the fellowship program education and**
277 **at least annually thereafter, as outlined in V.B.;** ^(Core)
278

279 **II.A.4.a).(5) have the authority to approve program faculty**
280 **members for participation in the fellowship program**
281 **education at all sites;** ^(Core)
282

- 283 II.A.4.a).(6) have the authority to remove program faculty
284 members from participation in the fellowship program
285 education at all sites; ^(Core)
286
287 II.A.4.a).(7) have the authority to remove fellows from supervising
288 interactions and/or learning environments that do not
289 meet the standards of the program; ^(Core)
290

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.

- 291
292 II.A.4.a).(8) submit accurate and complete information required
293 and requested by the DIO, GMEC, and ACGME; ^(Core)
294
295 II.A.4.a).(9) provide applicants who are offered an interview with
296 information related to the applicant's eligibility for the
297 relevant subspecialty board examination(s); ^(Core)
298
299 II.A.4.a).(10) provide a learning and working environment in which
300 fellows have the opportunity to raise concerns and
301 provide feedback in a confidential manner as
302 appropriate, without fear of intimidation or retaliation;
303 ^(Core)
304
305 II.A.4.a).(11) ensure the program's compliance with the Sponsoring
306 Institution's policies and procedures related to
307 grievances and due process; ^(Core)
308
309 II.A.4.a).(12) ensure the program's compliance with the Sponsoring
310 Institution's policies and procedures for due process
311 when action is taken to suspend or dismiss, not to
312 promote, or not to renew the appointment of a fellow;
313 ^(Core)
314

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.

- 315
316 II.A.4.a).(13) ensure the program's compliance with the Sponsoring
317 Institution's policies and procedures on employment
318 and non-discrimination; ^(Core)
319

- 320 **II.A.4.a).(13).(a)** **Fellows must not be required to sign a non-**
 321 **competition guarantee or restrictive covenant.**
 322 **(Core)**
- 323
- 324 **II.A.4.a).(14)** **document verification of program completion for all**
 325 **graduating fellows within 30 days; (Core)**
- 326
- 327 **II.A.4.a).(15)** **provide verification of an individual fellow’s**
 328 **completion upon the fellow’s request, within 30 days;**
 329 **and, (Core)**
- 330

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.

- 331
- 332 **II.A.4.a).(16)** **obtain review and approval of the Sponsoring**
 333 **Institution’s DIO before submitting information or**
 334 **requests to the ACGME, as required in the Institutional**
 335 **Requirements and outlined in the ACGME Program**
 336 **Director’s Guide to the Common Program**
 337 **Requirements. (Core)**
- 338

339 **II.B. Faculty**

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

353

354 ***Faculty members ensure that patients receive the level of care expected***
 355 ***from a specialist in the field. They recognize and respond to the needs of***
 356 ***the patients, fellows, community, and institution. Faculty members provide***
 357 ***appropriate levels of supervision to promote patient safety. Faculty***
 358 ***members create an effective learning environment by acting in a***
 359 ***professional manner and attending to the well-being of the fellows and***
 360 ***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.

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363 **II.B.1. For each participating site, there must be a sufficient number of**
364 **faculty members with competence to instruct and supervise all**
365 **fellows at that location.** ^(Core)
366
- 367 II.B.1.a) The neuroradiology faculty must include:
368
- 369 II.B.1.a).(1) a minimum of at least two neuroradiologists, including the
370 program director. ^(Core)
371
- 372 II.B.1.a).(1).(a) These faculty members should spend at least 80
373 percent of their time in the practice of
374 neuroradiology. ^(Core)
375
- 376 II.B.1.a).(2) There must be a minimum of at least one neuroradiologist
377 for every two fellows. ^(Core)
378
- 379 **II.B.2. Faculty members must:**
380
- 381 **II.B.2.a) be role models of professionalism;** ^(Core)
382
- 383 **II.B.2.b) demonstrate commitment to the delivery of safe, quality,**
384 **cost-effective, patient-centered care;** ^(Core)
385

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.

- 386
- 387 **II.B.2.c) demonstrate a strong interest in the education of fellows;** ^(Core)
388
- 389 **II.B.2.d) devote sufficient time to the educational program to fulfill**
390 **their supervisory and teaching responsibilities;** ^(Core)
391
- 392 **II.B.2.e) administer and maintain an educational environment**
393 **conducive to educating fellows;** ^(Core)
394
- 395 **II.B.2.f) regularly participate in organized clinical discussions,**
396 **rounds, journal clubs, and conferences; and,** ^(Core)
397
- 398 **II.B.2.g) pursue faculty development designed to enhance their skills**
399 **at least annually.** ^(Core)
400
- 401 II.B.2.h) The members of the faculty must regularly participate in clinical
402 discussions, journal clubs, clinical multidisciplinary conferences,
403 and research conferences. ^(Core)
404

Background and Intent: Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in

a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the fellowship program faculty in the aggregate.

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II.B.3. Faculty Qualifications

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

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

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

II.B.3.b).(1).(a) At least 50 percent of the physician faculty must have subspecialty certification in neuroradiology from the American Board of Radiology or the American Osteopathic Board of Radiology. (Core)

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

Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of fellows by non-physician educators enables the fellows to better manage patient care and provides valuable advancement of the fellows' knowledge. Furthermore, other individuals contribute to the education of the fellow in the basic science of the subspecialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the fellow, the program director may designate the individual as a program faculty member or a program core faculty member.

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

II.B.4. Core Faculty

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

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

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

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

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II.B.4.c) There must be at least two core faculty members, including the program director, who are neuroradiologists. ^(Core)

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II.C. Program Coordinator

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

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

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II.C.2.a) At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program: ^(Core)

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<u>Number of Approved Fellow Positions</u>	<u>Minimum FTE</u>
<u>1-3</u>	<u>0.3</u>
<u>4-7</u>	<u>0.4</u>
<u>8 or more</u>	<u>0.50</u>

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~~At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program as follows:~~

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Number of Approved Fellow Positions	Minimum Support Required (FTE)
1-6	0.1
7-8	0.2
9 or more	0.3

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

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

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

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

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II.D. Other Program Personnel

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

II.D.1. There must be nurses and technologists appropriately trained for invasive procedures and advanced imaging techniques. ^(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.

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III. Fellow Appointments

III.A. Eligibility Criteria

III.A.1. Eligibility Requirements – Fellowship Programs

491 All required clinical education for entry into ACGME-accredited
492 fellowship programs must be completed in an ACGME-accredited
493 residency program, an AOA-approved residency program, a
494 program with ACGME International (ACGME-I) Advanced Specialty
495 Accreditation, or a Royal College of Physicians and Surgeons of
496 Canada (RCPSC)-accredited or College of Family Physicians of
497 Canada (CFPC)-accredited residency program located in Canada.
498 (Core)
499

Background and Intent: Eligibility for ABMS or AOA Board certification may not be satisfied by fellowship training. Applicants must be notified of this at the time of application, as required in II.A.4.a).(9).

- 500
501 **III.A.1.a) Fellowship programs must receive verification of each**
502 **entering fellow’s level of competence in the required field,**
503 **upon matriculation, using ACGME, ACGME-I, or CanMEDS**
504 **Milestones evaluations from the core residency program. (Core)**
505
506 **III.A.1.b) Prerequisite clinical education for entry into a diagnostic radiology**
507 **subspecialty program should include the satisfactory completion of**
508 **a diagnostic radiology residency accredited by one of the**
509 **organizations identified in section III.A.1. (Core)**
510
511 **III.A.1.c) Fellow Eligibility Exception**
512
513 **The Review Committee for Radiology will allow the following**
514 **exception to the fellowship eligibility requirements:**
515
516 **III.A.1.c).(1) An ACGME-accredited fellowship program may accept**
517 **an exceptionally qualified international graduate**
518 **applicant who does not satisfy the eligibility**
519 **requirements listed in III.A.1., but who does meet all of**
520 **the following additional qualifications and conditions:**
521 **(Core)**
522
523 **III.A.1.c).(1).(a) evaluation by the program director and**
524 **fellowship selection committee of the**
525 **applicant’s suitability to enter the program,**
526 **based on prior training and review of the**
527 **summative evaluations of training in the core**
528 **specialty; and, (Core)**
529
530 **III.A.1.c).(1).(b) review and approval of the applicant’s**
531 **exceptional qualifications by the GMEC; and,**
532 **(Core)**
533
534 **III.A.1.c).(1).(c) verification of Educational Commission for**
535 **Foreign Medical Graduates (ECFMG)**
536 **certification. (Core)**
537

538 III.A.1.c).(2) Applicants accepted through this exception must have
539 an evaluation of their performance by the Clinical
540 Competency Committee within 12 weeks of
541 matriculation. ^(Core)
542

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

In recognition of the diversity of medical education and training around the world, this early evaluation of clinical competence required for these applicants ensures they can provide quality and safe patient care. Any gaps in competence should be addressed as per policies for fellows already established by the program in partnership with the Sponsoring Institution.

543
544 III.B. The program director must not appoint more fellows than approved by the
545 Review Committee. ^(Core)
546

547 III.B.1. All complement increases must be approved by the Review
548 Committee. ^(Core)
549

550 III.C. Fellow Transfers
551

552 The program must obtain verification of previous educational experiences
553 and a summative competency-based performance evaluation prior to
554 acceptance of a transferring fellow, and Milestones evaluations upon
555 matriculation. ^(Core)
556

557 IV. Educational Program
558

559 *The ACGME accreditation system is designed to encourage excellence and*
560 *innovation in graduate medical education regardless of the organizational*
561 *affiliation, size, or location of the program.*
562

563 *The educational program must support the development of knowledgeable, skillful*
564 *physicians who provide compassionate care.*
565

566 *In addition, the program is expected to define its specific program aims consistent*
567 *with the overall mission of its Sponsoring Institution, the needs of the community*
568 *it serves and that its graduates will serve, and the distinctive capabilities of*
569 *physicians it intends to graduate. While programs must demonstrate substantial*
570 *compliance with the Common and subspecialty-specific Program Requirements, it*
571 *is recognized that within this framework, programs may place different emphasis*
572 *on research, leadership, public health, etc. It is expected that the program aims*

573 *will reflect the nuanced program-specific goals for it and its graduates; for*
574 *example, it is expected that a program aiming to prepare physician-scientists will*
575 *have a different curriculum from one focusing on community health.*

576
577 **IV.A. The curriculum must contain the following educational components:** ^(Core)

578
579 **IV.A.1. a set of program aims consistent with the Sponsoring Institution’s**
580 **mission, the needs of the community it serves, and the desired**
581 **distinctive capabilities of its graduates;** ^(Core)

582
583 **IV.A.1.a) The program’s aims must be made available to program**
584 **applicants, fellows, and faculty members.** ^(Core)

585
586 **IV.A.2. competency-based goals and objectives for each educational**
587 **experience designed to promote progress on a trajectory to**
588 **autonomous practice in their subspecialty. These must be**
589 **distributed, reviewed, and available to fellows and faculty members;**
590 ^(Core)

591
592 **IV.A.3. delineation of fellow responsibilities for patient care, progressive**
593 **responsibility for patient management, and graded supervision in**
594 **their subspecialty;** ^(Core)

595

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.

596

597 **IV.A.4. structured educational activities beyond direct patient care; and,**
598 ^(Core)

599

Background and Intent: Patient care-related educational activities, such as morbidity and mortality conferences, tumor boards, surgical planning conferences, case discussions, etc., allow fellows to gain medical knowledge directly applicable to the patients they serve. Programs should define those educational activities in which fellows are expected to participate and for which time is protected. Further specification can be found in IV.C.

600

601 **IV.A.5. advancement of fellows’ knowledge of ethical principles**
602 **foundational to medical professionalism.** ^(Core)

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IV.B. ACGME Competencies

Background and Intent: The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each subspecialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each subspecialty. The focus

in fellowship is on subspecialty-specific patient care and medical knowledge, as well as refining the other competencies acquired in residency.

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

IV.B.1.a) Professionalism

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

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

Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, equitable, and designed to improve population health, while reducing per capita costs. (See the Institute of Medicine [IOM]'s *Crossing the Quality Chasm: A New Health System for the 21st Century*, 2001 and Berwick D, Nolan T, Whittington J. *The Triple Aim: care, cost, and quality. Health Affairs*. 2008; 27(3):759-769.). In addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.

These organizing principles inform the Common Program Requirements across all Competency domains. Specific content is determined by the Review Committees with input from the appropriate professional societies, certifying boards, and the community.

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IV.B.1.b).(1) Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. ^(Core)

IV.B.1.b).(1).(a) Fellows must demonstrate competence in providing consultation, and in the interpretation of imaging diseases of the brain, spine, neck, organs of special sense, and vascular supply to these regions utilizing CT, MRI, magnetic resonance (MR) angiography, radiography, ultrasound, and nuclear radiology, including PET. ^(Core)

IV.B.1.b).(2) Fellows must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. ^(Core)

Subspecialty-Specific Background and Intent: Knowledge of neurovascular anatomy and pathology is a key component of neuroradiology education and practice. It is expected that programs continue to educate fellows in the full spectrum of imaging of the vascular system of the brain, head and neck, and spine, including education on the angiographic evaluation of these areas. Although the requirement for performing the technical skills of angiography have changed, programs are still expected to have fellows participate in the angiographic evaluation of patients. Ideally this would still occur during rotations on neuro-interventional services and would involve participation in performing and interpreting angiography, however,

programs are now given more flexibility in the number of procedures performed by the fellow. In no way should the change in the requirement for number of angiography procedures be interpreted as eliminating the need for education of vascular imaging, including the consultation and interpretation of neuro-angiography as required in IV.B.1.b).(1).(a). Any angiography procedures performed by a fellow would count toward the requirement for 100 image-guided invasive procedures (IV.B.1.b).(2).(b).(iv)).

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636	IV.B.1.b).(2).(a)	Fellows must demonstrate competence in the performance and/or interpretation of the following:
637		(Core)
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639		
640	IV.B.1.b).(2).(a).(i)	3000 neuroradiological exams, including CT and MR, of which at least 1500 are neuroradiological MR scans; (Core)
641		
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644	IV.B.1.b).(2).(a).(ii)	250 vascular examinations, including computed tomography angiogram (CTA), computed tomography venogram (CTV), magnetic resonance angiogram (MRA), magnetic resonance venogram (MRV), Doppler ultrasound, and catheter-based angiography; and, (Core)
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652	IV.B.1.b).(2).(a).(iii)	100 image-guided invasive procedures. (Core)
653		
654	IV.B.1.b).(2).(b)	Fellows must demonstrate competence in performing image-guided access to the spinal subarachnoid space for the purposes of myelography, cerebral spinal fluid (CSF) analysis, and/or instillation of therapeutic agents. (Core)
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660	IV.B.1.b).(2).(c)	Fellows must demonstrate competence in performing relevant patient evaluation, demonstrating patient management skills, and relevant pharmacology skills, including obtaining informed consent and monitoring for complications. (Core)
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667	IV.B.1.c)	Medical Knowledge
668		
669		Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. (Core)
670		
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674	IV.B.1.c).(1)	Fellows must demonstrate competence in their knowledge of the following: (Core)
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677	IV.B.1.c).(1).(a)	indications and contraindications for, and the role of interventional neuroangiography in patient care management and treatment; (Core)
678		
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681 IV.B.1.c).(1).(b) indications, limitations, risks, alternatives, and
682 appropriate utilization of neuroradiologic imaging
683 and interventional procedures; ^(Core)
684
685 IV.B.1.c).(1).(c) pathophysiology, pathology, anatomy, and genetics
686 of diseases that affect the brain, neck, and spine,
687 including congenital, traumatic, vascular,
688 neoplastic, infectious, inflammatory, metabolic, and
689 neurodegenerative disorders; ^(Core)
690
691 IV.B.1.c).(1).(d) consequences on neuroradiologic imaging of
692 medical and surgical treatments of diseases of the
693 brain, spine, and head and neck; ^(Core)
694
695 IV.B.1.c).(1).(e) all aspects of administering and monitoring
696 sedation; ^(Core)
697
698 IV.B.1.c).(1).(f) radiologic sciences with an emphasis on CT and
699 MR physics, radiation biology, and the
700 pharmacology of radiographic contrast materials;
701 and, ^(Core)
702
703 IV.B.1.c).(1).(g) advanced techniques, such as magnetic resonance
704 spectroscopy (MRS) and functional activation
705 studies (fMRI). ^(Core)
706

707 **IV.B.1.d)**

Practice-based Learning and Improvement

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

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

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

- 714
715 **IV.B.1.e)**

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)

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722 **IV.B.1.f)**

Systems-based Practice

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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)

IV.C. Curriculum Organization and Fellow Experiences

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

IV.C.1.a) The assignment of educational experiences should be structured to minimize the frequency of transitions. ^{(Detail)†}

IV.C.1.b) Educational experiences should be of sufficient length to provide a quality educational experience defined by ongoing supervision, longitudinal relationships with faculty members, and high-quality assessment and feedback. ^(Detail)

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

IV.C.3. The program must provide fellows with an organized, comprehensive, and supervised, full-time educational experience in the selection, interpretation, and performance of neuroradiologic examinations and procedures. ^(Core)

IV.C.4. The curriculum must contain the following didactic components:

IV.C.4.a) departmental and/or interdepartmental conferences with allied clinical departments that should be held weekly; ^(Core)

IV.C.4.b) morbidity and mortality review related to the performance of interventional procedures; and, ^(Core)

IV.C.4.b).(1) This review should be conducted four times a year. ^(Core)

IV.C.4.c) journal club that should be conducted on a regular basis. ^(Core)

IV.C.4.c).(1) Fellows should present and lead discussions on current peer-reviewed articles pertaining to the specialty of neuroradiology. ^(Core)

IV.C.5. The program curriculum must provide:

IV.C.5.a) experience in pediatric neuroradiology; ^(Core)

- 773 IV.C.5.a).(1) There should be a minimum of four weeks or equivalent
774 longitudinal experience in pediatric neuroradiology. (Core)
775
776 IV.C.5.b) experience in head and neck radiology; (Core)
777
778 IV.C.5.b).(1) There should be a minimum of four weeks or equivalent
779 longitudinal experience in head and neck radiology. (Core)
780
781 IV.C.5.c) experience in spine radiology, including non-invasive studies and
782 image-guided procedures; (Core)
783
784 IV.C.5.c).(1) There should be a minimum of four weeks or equivalent
785 longitudinal experience in spine radiology. (Core)
786
787 IV.C.5.d) experience in vascular neuroradiology; and, (Core)
788
789 IV.C.5.e) general experience in neuroradiology. (Core)
790
791 IV.C.5.e).(1) This should include exposure to new and evolving
792 techniques such as Perfusion Imaging (CTP and MRP),
793 MR spectroscopy, Diffusion Weighed Imaging (DWI),
794 Diffusion Tension Imaging (DTI), fMRI, and PET. (Core)
795
796 IV.C.6. Fellows must interpret non-invasive and invasive diagnostic catheter-
797 based cervicocerebral angiography. (Core)
798
799 IV.C.7. Fellows should participate in catheter-based angiography and pre- and
800 post-procedural care of patients undergoing angiography. (Core)
801
802 IV.C.7.a) There should be a minimum of four weeks or equivalent
803 longitudinal experience in vascular neuroradiology. (Core)
804
805 IV.C.8. Fellows must maintain advanced cardiac life support certification. (Core)
806
807 IV.C.9. Fellows must document their exposure to magnetic resonance
808 spectroscopy (MRS) and functional activation studies (fMRI). (Core)
809
810 IV.C.10. Fellows must document their performance of invasive cases in a
811 procedure log. (Core)
812

813 IV.D. Scholarship

814
815 ***Medicine is both an art and a science. The physician is a humanistic***
816 ***scientist who cares for patients. This requires the ability to think critically,***
817 ***evaluate the literature, appropriately assimilate new knowledge, and***
818 ***practice lifelong learning. The program and faculty must create an***
819 ***environment that fosters the acquisition of such skills through fellow***
820 ***participation in scholarly activities as defined in the subspecialty-specific***
821 ***Program Requirements. Scholarly activities may include discovery,***
822 ***integration, application, and teaching.***
823

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

832
833 **IV.D.1. Program Responsibilities**

834
835 **IV.D.1.a) The program must demonstrate evidence of scholarly**
836 **activities, consistent with its mission(s) and aims. ^(Core)**

837
838 **IV.D.1.b) The program in partnership with its Sponsoring Institution,**
839 **must allocate adequate resources to facilitate fellow and**
840 **faculty involvement in scholarly activities. ^(Core)**

841
842 **IV.D.2. Faculty Scholarly Activity**

843
844 **IV.D.2.a) Among their scholarly activity, programs must demonstrate**
845 **accomplishments in at least three of the following domains:**
846 **^(Core)**

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848
 - 849 • **Research in basic science, education, translational**
 - 850 **science, patient care, or population health**
 - 851 • **Peer-reviewed grants**
 - 852 • **Quality improvement and/or patient safety initiatives**
 - 853 • **Systematic reviews, meta-analyses, review articles,**
 - 854 **chapters in medical textbooks, or case reports**
 - 855 • **Creation of curricula, evaluation tools, didactic**
 - 856 **educational activities, or electronic educational**
 - 857 **materials**
 - 858 • **Contribution to professional committees, educational**
 - 859 **organizations, or editorial boards**
 - 860 • **Innovations in education**

861 **IV.D.2.b) The program must demonstrate dissemination of scholarly**
862 **activity within and external to the program by the following**
863 **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.

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866	IV.D.2.b).(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)‡
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875	IV.D.2.b).(2)	peer-reviewed publication. (Outcome)
876		
877	IV.D.3.	Fellow Scholarly Activity
878		
879	IV.D.3.a)	Fellows should be provided with instruction in the fundamentals of experimental design, performance, and interpretation of results. (Core)
880		
881		
882		
883	IV.D.3.a).(1)	This instruction should facilitate fellows' development of competence in the critical assessment of new imaging modalities and of new procedures in neuroradiology. (Detail)
884		
885		
886		
887	IV.D.3.b)	Fellows should participate in clinical, basic biomedical, or health services research projects. (Core)
888		
889		
890	IV.D.3.b).(1)	Fellows should undertake at least one project as principal investigator. (Detail)
891		
892		
893	IV.D.3.c)	Fellows should submit at least one scientific paper or exhibit for presentation at a regional or national meeting. (Core)
894		
895		
896	V.	Evaluation
897		
898	V.A.	Fellow Evaluation
899		
900	V.A.1.	Feedback and Evaluation
901		

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.

- 902
903 **V.A.1.a) Faculty members must directly observe, evaluate, and**
904 **frequently provide feedback on fellow performance during**
905 **each rotation or similar educational assignment. ^(Core)**
906
907 V.A.1.a).(1) Fellow assessment must include quarterly meetings with
908 the program director to discuss performance and methods
909 for improvement. ^(Core)
910
911 V.A.1.a).(1).(a) These meetings must include a review of the
912 fellows' procedure log. ^(Core)
913
914 V.A.1.a).(2) Fellows must receive feedback concerning their
915 radiological reports, including content, grammar, and style.
916 ^(Core)
917
918 V.A.1.a).(2).(a) These reports must be signed by a neuroradiology
919 faculty member. ^(Core)
920

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.

- 921
922 **V.A.1.b) Evaluation must be documented at the completion of the**
923 **assignment. ^(Core)**
924
925 **V.A.1.b).(1) For block rotations of greater than three months in**
926 **duration, evaluation must be documented at least**
927 **every three months. ^(Core)**
928
929 **V.A.1.b).(2) Longitudinal experiences such as continuity clinic in**
930 **the context of other clinical responsibilities must be**
931 **evaluated at least every three months and at**
932 **completion. ^(Core)**
933

- 934 **V.A.1.c)** The program must provide an objective performance
 935 evaluation based on the Competencies and the subspecialty-
 936 specific Milestones, and must: ^(Core)
 937
 938 **V.A.1.c).(1)** use multiple evaluators (e.g., faculty members, peers,
 939 patients, self, and other professional staff members);
 940 and, ^(Core)
 941
 942 **V.A.1.c).(2)** provide that information to the Clinical Competency
 943 Committee for its synthesis of progressive fellow
 944 performance and improvement toward unsupervised
 945 practice. ^(Core)
 946

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.

- 947
 948 **V.A.1.d)** The program director or their designee, with input from the
 949 Clinical Competency Committee, must:
 950
 951 **V.A.1.d).(1)** meet with and review with each fellow their
 952 documented semi-annual evaluation of performance,
 953 including progress along the subspecialty-specific
 954 Milestones. ^(Core)
 955
 956 **V.A.1.d).(2)** assist fellows in developing individualized learning
 957 plans to capitalize on their strengths and identify areas
 958 for growth; and, ^(Core)
 959
 960 **V.A.1.d).(3)** develop plans for fellows failing to progress, following
 961 institutional policies and procedures. ^(Core)
 962

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.

- 963
964 **V.A.1.e)** At least annually, there must be a summative evaluation of
965 each fellow that includes their readiness to progress to the
966 next year of the program, if applicable. ^(Core)
967
- 968 **V.A.1.f)** The evaluations of a fellow's performance must be accessible
969 for review by the fellow. ^(Core)
970
- 971 **V.A.2.** Final Evaluation
972
- 973 **V.A.2.a)** The program director must provide a final evaluation for each
974 fellow upon completion of the program. ^(Core)
975
- 976 **V.A.2.a).(1)** The subspecialty-specific Milestones, and when
977 applicable the subspecialty-specific Case Logs, must
978 be used as tools to ensure fellows are able to engage
979 in autonomous practice upon completion of the
980 program. ^(Core)
981
- 982 **V.A.2.a).(2)** The final evaluation must:
983
- 984 **V.A.2.a).(2).(a)** become part of the fellow's permanent record
985 maintained by the institution, and must be
986 accessible for review by the fellow in
987 accordance with institutional policy; ^(Core)
988
- 989 **V.A.2.a).(2).(b)** verify that the fellow has demonstrated the
990 knowledge, skills, and behaviors necessary to
991 enter autonomous practice; ^(Core)
992
- 993 **V.A.2.a).(2).(c)** consider recommendations from the Clinical
994 Competency Committee; and, ^(Core)
995
- 996 **V.A.2.a).(2).(d)** be shared with the fellow upon completion of
997 the program. ^(Core)
998
- 999 **V.A.3.** A Clinical Competency Committee must be appointed by the
1000 program director. ^(Core)
1001
- 1002 **V.A.3.a)** At a minimum the Clinical Competency Committee must
1003 include three members, at least one of whom is a core faculty
1004 member. Members must be faculty members from the same
1005 program or other programs, or other health professionals
1006 who have extensive contact and experience with the
1007 program's fellows. ^(Core)
1008

- 1009 **V.A.3.b)** **The Clinical Competency Committee must:**
 1010
 1011 **V.A.3.b).(1)** **review all fellow evaluations at least semi-annually;**
 1012 **(Core)**
 1013
 1014 **V.A.3.b).(2)** **determine each fellow’s progress on achievement of**
 1015 **the subspecialty-specific Milestones; and, (Core)**
 1016
 1017 **V.A.3.b).(3)** **meet prior to the fellows’ semi-annual evaluations and**
 1018 **advise the program director regarding each fellow’s**
 1019 **progress. (Core)**
 1020
 1021 **V.B. Faculty Evaluation**
 1022
 1023 **V.B.1. The program must have a process to evaluate each faculty**
 1024 **member’s performance as it relates to the educational program at**
 1025 **least annually. (Core)**
 1026

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

- 1027
 1028 **V.B.1.a)** **This evaluation must include a review of the faculty member’s**
 1029 **clinical teaching abilities, engagement with the educational**
 1030 **program, participation in faculty development related to their**
 1031 **skills as an educator, clinical performance, professionalism,**
 1032 **and scholarly activities. (Core)**
 1033
 1034 **V.B.1.b)** **This evaluation must include written, confidential evaluations**
 1035 **by the fellows. (Core)**
 1036
 1037 **V.B.2. Faculty members must receive feedback on their evaluations at least**
 1038 **annually. (Core)**
 1039

1040 **V.B.3. Results of the faculty educational evaluations should be**
1041 **incorporated into program-wide faculty development plans. (Core)**
1042

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.

1043
1044 **V.C. Program Evaluation and Improvement**
1045

1046 **V.C.1. The program director must appoint the Program Evaluation**
1047 **Committee to conduct and document the Annual Program**
1048 **Evaluation as part of the program’s continuous improvement**
1049 **process. (Core)**
1050

1051 **V.C.1.a) The Program Evaluation Committee must be composed of at**
1052 **least two program faculty members, at least one of whom is a**
1053 **core faculty member, and at least one fellow. (Core)**
1054

1055 **V.C.1.b) Program Evaluation Committee responsibilities must include:**
1056

1057 **V.C.1.b).(1) acting as an advisor to the program director, through**
1058 **program oversight; (Core)**
1059

1060 **V.C.1.b).(2) review of the program’s self-determined goals and**
1061 **progress toward meeting them; (Core)**
1062

1063 **V.C.1.b).(3) guiding ongoing program improvement, including**
1064 **development of new goals, based upon outcomes;**
1065 **and, (Core)**
1066

1067 **V.C.1.b).(4) review of the current operating environment to identify**
1068 **strengths, challenges, opportunities, and threats as**
1069 **related to the program’s mission and aims. (Core)**
1070

Background and Intent: In order to achieve its mission and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of fellows and faculty members is a reflection of program quality, and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program’s progress toward achievement of its goals and aims.

1071
1072 **V.C.1.c) The Program Evaluation Committee should consider the**
1073 **following elements in its assessment of the program:**
1074

1075 **V.C.1.c).(1) curriculum; (Core)**
1076

1077 **V.C.1.c).(2) outcomes from prior Annual Program Evaluation(s);**
1078 **(Core)**

1079		
1080	V.C.1.c).(3)	ACGME letters of notification, including citations, Areas for Improvement, and comments; ^(Core)
1081		
1082		
1083	V.C.1.c).(4)	quality and safety of patient care; ^(Core)
1084		
1085	V.C.1.c).(5)	aggregate fellow and faculty:
1086		
1087	V.C.1.c).(5).(a)	well-being; ^(Core)
1088		
1089	V.C.1.c).(5).(b)	recruitment and retention; ^(Core)
1090		
1091	V.C.1.c).(5).(c)	workforce diversity; ^(Core)
1092		
1093	V.C.1.c).(5).(d)	engagement in quality improvement and patient safety; ^(Core)
1094		
1095		
1096	V.C.1.c).(5).(e)	scholarly activity; ^(Core)
1097		
1098	V.C.1.c).(5).(f)	ACGME Resident/Fellow and Faculty Surveys (where applicable); and, ^(Core)
1099		
1100		
1101	V.C.1.c).(5).(g)	written evaluations of the program. ^(Core)
1102		
1103	V.C.1.c).(6)	aggregate fellow:
1104		
1105	V.C.1.c).(6).(a)	achievement of the Milestones; ^(Core)
1106		
1107	V.C.1.c).(6).(b)	in-training examinations (where applicable); ^(Core)
1108		
1109		
1110	V.C.1.c).(6).(c)	board pass and certification rates; and, ^(Core)
1111		
1112	V.C.1.c).(6).(d)	graduate performance. ^(Core)
1113		
1114	V.C.1.c).(7)	aggregate faculty:
1115		
1116	V.C.1.c).(7).(a)	evaluation; and, ^(Core)
1117		
1118	V.C.1.c).(7).(b)	professional development ^(Core)
1119		
1120	V.C.1.d)	The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. ^(Core)
1121		
1122		
1123		
1124	V.C.1.e)	The annual review, including the action plan, must:
1125		
1126	V.C.1.e).(1)	be distributed to and discussed with the members of the teaching faculty and the fellows; and, ^(Core)
1127		
1128		
1129	V.C.1.e).(2)	be submitted to the DIO. ^(Core)

1130
1131 **V.C.2.** The program must participate in a Self-Study prior to its 10-Year
1132 Accreditation Site Visit. ^(Core)

1133
1134 **V.C.2.a)** A summary of the Self-Study must be submitted to the DIO.
1135 ^(Core)
1136

Background and Intent: Outcomes of the documented Annual Program Evaluation can be integrated into the 10-year Self-Study process. The Self-Study is an objective, comprehensive evaluation of the fellowship program, with the aim of improving it. Underlying the Self-Study is this longitudinal evaluation of the program and its learning environment, facilitated through sequential Annual Program Evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement. Details regarding the timing and expectations for the Self-Study and the 10-Year Accreditation Site Visit are provided in the *ACGME Manual of Policies and Procedures*. Additionally, a description of the [Self-Study process](#), as well as information on how to prepare for the [10-Year Accreditation Site Visit](#), is available on the ACGME website.

1137
1138 **V.C.3.** *One goal of ACGME-accredited education is to educate physicians*
1139 *who seek and achieve board certification. One measure of the*
1140 *effectiveness of the educational program is the ultimate pass rate.*

1141
1142 *The program director should encourage all eligible program*
1143 *graduates to take the certifying examination offered by the*
1144 *applicable American Board of Medical Specialties (ABMS) member*
1145 *board or American Osteopathic Association (AOA) certifying board.*

1146
1147 **V.C.3.a)** For subspecialties in which the ABMS member board and/or
1148 AOA certifying board offer(s) an annual written exam, in the
1149 preceding three years, the program's aggregate pass rate of
1150 those taking the examination for the first time must be higher
1151 than the bottom fifth percentile of programs in that
1152 subspecialty. ^(Outcome)

1153
1154 **V.C.3.b)** For subspecialties in which the ABMS member board and/or
1155 AOA certifying board offer(s) a biennial written exam, in the
1156 preceding six years, the program's aggregate pass rate of
1157 those taking the examination for the first time must be higher
1158 than the bottom fifth percentile of programs in that
1159 subspecialty. ^(Outcome)

1160
1161 **V.C.3.c)** For subspecialties in which the ABMS member board and/or
1162 AOA certifying board offer(s) an annual oral exam, in the
1163 preceding three years, the program's aggregate pass rate of
1164 those taking the examination for the first time must be higher
1165 than the bottom fifth percentile of programs in that
1166 subspecialty. ^(Outcome)

1167
1168 **V.C.3.d)** For subspecialties in which the ABMS member board and/or
1169 AOA certifying board offer(s) a biennial oral exam, in the

1170 preceding six years, the program's aggregate pass rate of
1171 those taking the examination for the first time must be higher
1172 than the bottom fifth percentile of programs in that
1173 subspecialty. ^(Outcome)

1174
1175 **V.C.3.e)** For each of the exams referenced in V.C.3.a)-d), any program
1176 whose graduates over the time period specified in the
1177 requirement have achieved an 80 percent pass rate will have
1178 met this requirement, no matter the percentile rank of the
1179 program for pass rate in that subspecialty. ^(Outcome)
1180

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

There are subspecialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

1181
1182 **V.C.3.f)** Programs must report, in ADS, board certification status
1183 annually for the cohort of board-eligible fellows that
1184 graduated seven years earlier. ^(Core)
1185

Background and Intent: It is essential that fellowship programs demonstrate knowledge and skill transfer to their fellows. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from fellowship graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

1186
1187 **VI. The Learning and Working Environment**
1188

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***

1194

- 1195 • *Excellence in the safety and quality of care rendered to patients by today's*
- 1196 *fellows in their future practice*
- 1197
- 1198 • *Excellence in professionalism through faculty modeling of:*
- 1199
- 1200 ○ *the effacement of self-interest in a humanistic environment that supports*
- 1201 *the professional development of physicians*
- 1202
- 1203 ○ *the joy of curiosity, problem-solving, intellectual rigor, and discovery*
- 1204
- 1205 • *Commitment to the well-being of the students, residents, fellows, faculty*
- 1206 *members, and all members of the health care team*
- 1207

Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and fellows more discretion to structure clinical education in a way that best supports the above principles of professional development. With this increased flexibility comes the responsibility for programs and fellows to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, fellow education, and fellow well-being. The requirements are intended to support the development of a sense of professionalism by encouraging fellows to make decisions based on patient needs and their own well-being, without fear of jeopardizing their program's accreditation status. In addition, the proposed requirements eliminate the burdensome documentation requirement for fellows to justify clinical and educational work hour variations.

Clinical and educational work hours represent only one part of the larger issue of conditions of the learning and working environment, and Section VI has now been expanded to include greater attention to patient safety and fellow and faculty member well-being. The requirements are intended to support programs and fellows as they strive for excellence, while also ensuring ethical, humanistic training. Ensuring that flexibility is used in an appropriate manner is a shared responsibility of the program and fellows. With this flexibility comes a responsibility for fellows and faculty members to recognize the need to hand off care of a patient to another provider when a fellow is too fatigued to provide safe, high quality care and for programs to ensure that fellows remain within the 80-hour maximum weekly limit.

- 1208
- 1209 **VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability**
- 1210
- 1211 **VI.A.1. Patient Safety and Quality Improvement**
- 1212
- 1213 *All physicians share responsibility for promoting patient safety and*
- 1214 *enhancing quality of patient care. Graduate medical education must*
- 1215 *prepare fellows to provide the highest level of clinical care with*
- 1216 *continuous focus on the safety, individual needs, and humanity of*
- 1217 *their patients. It is the right of each patient to be cared for by fellows*
- 1218 *who are appropriately supervised; possess the requisite knowledge,*
- 1219 *skills, and abilities; understand the limits of their knowledge and*
- 1220 *experience; and seek assistance as required to provide optimal*
- 1221 *patient care.*

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

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

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

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

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

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

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

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

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

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

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

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1271		
1272	VI.A.1.a).(3).(a)	Residents, fellows, faculty members, and other clinical staff members must:
1273		
1274		
1275	VI.A.1.a).(3).(a).(i)	know their responsibilities in reporting patient safety events at the clinical site;
1276		(Core)
1277		
1278		
1279	VI.A.1.a).(3).(a).(ii)	know how to report patient safety events, including near misses, at the clinical site; and,
1280		(Core)
1281		
1282		
1283	VI.A.1.a).(3).(a).(iii)	be provided with summary information of their institution’s patient safety reports.
1284		(Core)
1285		
1286		
1287	VI.A.1.a).(3).(b)	Fellows must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.
1288		(Core)
1289		
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1293		
1294	VI.A.1.a).(4)	Fellow Education and Experience in Disclosure of Adverse Events
1295		
1296		
1297		<i>Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for fellows to develop and apply.</i>
1298		
1299		
1300		
1301		
1302		
1303	VI.A.1.a).(4).(a)	All fellows must receive training in how to disclose adverse events to patients and families.
1304		(Core)
1305		
1306		
1307	VI.A.1.a).(4).(b)	Fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated.
1308		(Detail)
1309		
1310		
1311	VI.A.1.b)	Quality Improvement
1312		
1313	VI.A.1.b).(1)	Education in Quality Improvement
1314		
1315		<i>A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.</i>
1316		
1317		
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1320	VI.A.1.b).(1).(a)	Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities. ^(Core)
1321		
1322		
1323		
1324	VI.A.1.b).(2)	Quality Metrics
1325		
1326		<i>Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.</i>
1327		
1328		
1329		
1330	VI.A.1.b).(2).(a)	Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. ^(Core)
1331		
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1334	VI.A.1.b).(3)	Engagement in Quality Improvement Activities
1335		
1336		<i>Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.</i>
1337		
1338		
1339		
1340	VI.A.1.b).(3).(a)	Fellows must have the opportunity to participate in interprofessional quality improvement activities. ^(Core)
1341		
1342		
1343		
1344	VI.A.1.b).(3).(a).(i)	This should include activities aimed at reducing health care disparities. ^(Detail)
1345		
1346		
1347	VI.A.2.	Supervision and Accountability
1348		
1349	VI.A.2.a)	<i>Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.</i>
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1357		
1358		<i>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.</i>
1359		
1360		
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1363		
1364	VI.A.2.a).(1)	Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. ^(Core)
1365		
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- 1371 VI.A.2.a).(1).(a) This information must be available to fellows,
 1372 faculty members, other members of the health
 1373 care team, and patients. ^(Core)
 1374
 1375 VI.A.2.a).(1).(b) Fellows and faculty members must inform each
 1376 patient of their respective roles in that patient's
 1377 care when providing direct patient care. ^(Core)
 1378
 1379 VI.A.2.b) *Supervision may be exercised through a variety of methods.*
 1380 *For many aspects of patient care, the supervising physician*
 1381 *may be a more advanced fellow. Other portions of care*
 1382 *provided by the fellow can be adequately supervised by the*
 1383 *appropriate availability of the supervising faculty member or*
 1384 *fellow, either on site or by means of telecommunication*
 1385 *technology. Some activities require the physical presence of*
 1386 *the supervising faculty member. In some circumstances,*
 1387 *supervision may include post-hoc review of fellow-delivered*
 1388 *care with feedback.*
 1389

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

- 1390
 1391 VI.A.2.b).(1) The program must demonstrate that the appropriate
 1392 level of supervision in place for all fellows is based on
 1393 each fellow's level of training and ability, as well as
 1394 patient complexity and acuity. Supervision may be
 1395 exercised through a variety of methods, as appropriate
 1396 to the situation. ^(Core)
 1397
 1398 VI.A.2.b).(2) The program must define when physical presence of a
 1399 supervising physician is required. ^(Core)
 1400
 1401 VI.A.2.c) Levels of Supervision
 1402
 1403 To promote appropriate fellow supervision while providing
 1404 for graded authority and responsibility, the program must use
 1405 the following classification of supervision: ^(Core)
 1406
 1407 VI.A.2.c).(1) Direct Supervision:
 1408
 1409 VI.A.2.c).(1).(a) the supervising physician is physically present
 1410 with the fellow during the key portions of the
 1411 patient interaction; or, ^(Core)
 1412

1413	VI.A.2.c).(1).(b)	the supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology. ^(Core)
1414		
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1419	VI.A.2.c).(1).(b).(i)	The program must have clear guidelines that delineate which competencies must be met to determine when a fellow can progress to indirect supervision. ^(Core)
1420		
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1424	VI.A.2.c).(1).(b).(ii)	The program director must ensure that clear expectations exist and are communicated to the fellows, and that these expectations outline specific situations in which a fellow would still require direct supervision. ^(Core)
1425		
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1430	VI.A.2.c).(2)	Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the fellow for guidance and is available to provide appropriate direct supervision. ^(Core)
1431		
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1436	VI.A.2.c).(3)	Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. ^(Core)
1437		
1438		
1439		
1440	VI.A.2.d)	The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. ^(Core)
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1445	VI.A.2.d).(1)	The program director must evaluate each fellow’s abilities based on specific criteria, guided by the Milestones. ^(Core)
1446		
1447		
1448		
1449	VI.A.2.d).(2)	Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow. ^(Core)
1450		
1451		
1452		
1453		
1454	VI.A.2.d).(3)	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)
1455		
1456		
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1459		
1460	VI.A.2.e)	Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s). ^(Core)
1461		
1462		
1463		

1464 VI.A.2.e).(1) Each fellow must know the limits of their scope of
1465 authority, and the circumstances under which the
1466 fellow is permitted to act with conditional
1467 independence. ^(Outcome)
1468

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

1469
1470 VI.A.2.f) Faculty supervision assignments must be of sufficient
1471 duration to assess the knowledge and skills of each fellow
1472 and to delegate to the fellow the appropriate level of patient
1473 care authority and responsibility. ^(Core)
1474

1475 VI.B. Professionalism

1476
1477 VI.B.1. Programs, in partnership with their Sponsoring Institutions, must
1478 educate fellows and faculty members concerning the professional
1479 responsibilities of physicians, including their obligation to be
1480 appropriately rested and fit to provide the care required by their
1481 patients. ^(Core)
1482

1483 VI.B.2. The learning objectives of the program must:

1484
1485 VI.B.2.a) be accomplished through an appropriate blend of supervised
1486 patient care responsibilities, clinical teaching, and didactic
1487 educational events; ^(Core)
1488

1489 VI.B.2.b) be accomplished without excessive reliance on fellows to
1490 fulfill non-physician obligations; and, ^(Core)
1491

Background and Intent: Routine reliance on fellows to fulfill non-physician obligations increases work compression for fellows and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that fellows may be expected to do any of these things on occasion when the need arises, these activities should not be performed by fellows routinely and must be kept to a minimum to optimize fellow education.

1492
1493 VI.B.2.c) ensure manageable patient care responsibilities. ^(Core)
1494

Background and Intent: The Common Program Requirements do not define “manageable patient care responsibilities” as this is variable by specialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully

assess how the assignment of patient care responsibilities can affect work compression.

- 1495
1496 **VI.B.3.** **The program director, in partnership with the Sponsoring Institution,**
1497 **must provide a culture of professionalism that supports patient**
1498 **safety and personal responsibility.** ^(Core)
1499
1500 **VI.B.4.** **Fellows and faculty members must demonstrate an understanding**
1501 **of their personal role in the:**
1502
1503 **VI.B.4.a)** **provision of patient- and family-centered care;** ^(Outcome)
1504
1505 **VI.B.4.b)** **safety and welfare of patients entrusted to their care,**
1506 **including the ability to report unsafe conditions and adverse**
1507 **events;** ^(Outcome)
1508

Background and Intent: This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the fellow.

- 1509
1510 **VI.B.4.c)** **assurance of their fitness for work, including;** ^(Outcome)
1511

Background and Intent: This requirement emphasizes the professional responsibility of faculty members and fellows to arrive for work adequately rested and ready to care for patients. It is also the responsibility of faculty members, fellows, and other members of the care team to be observant, to intervene, and/or to escalate their concern about fellow and faculty member fitness for work, depending on the situation, and in accordance with institutional policies.

- 1512
1513 **VI.B.4.c).(1)** **management of their time before, during, and after**
1514 **clinical assignments; and,** ^(Outcome)
1515
1516 **VI.B.4.c).(2)** **recognition of impairment, including from illness,**
1517 **fatigue, and substance use, in themselves, their peers,**
1518 **and other members of the health care team.** ^(Outcome)
1519
1520 **VI.B.4.d)** **commitment to lifelong learning;** ^(Outcome)
1521
1522 **VI.B.4.e)** **monitoring of their patient care performance improvement**
1523 **indicators; and,** ^(Outcome)
1524
1525 **VI.B.4.f)** **accurate reporting of clinical and educational work hours,**
1526 **patient outcomes, and clinical experience data.** ^(Outcome)
1527
1528 **VI.B.5.** **All fellows and faculty members must demonstrate responsiveness**
1529 **to patient needs that supersedes self-interest. This includes the**
1530 **recognition that under certain circumstances, the best interests of**
1531 **the patient may be served by transitioning that patient's care to**
1532 **another qualified and rested provider.** ^(Outcome)
1533

1534 VI.B.6. Programs, in partnership with their Sponsoring Institutions, must
1535 provide a professional, equitable, respectful, and civil environment
1536 that is free from discrimination, sexual and other forms of
1537 harassment, mistreatment, abuse, or coercion of students, fellows,
1538 faculty, and staff. ^(Core)
1539

1540 VI.B.7. Programs, in partnership with their Sponsoring Institutions, should
1541 have a process for education of fellows and faculty regarding
1542 unprofessional behavior and a confidential process for reporting,
1543 investigating, and addressing such concerns. ^(Core)
1544

1545 VI.C. Well-Being
1546

1547 *Psychological, emotional, and physical well-being are critical in the*
1548 *development of the competent, caring, and resilient physician and require*
1549 *proactive attention to life inside and outside of medicine. Well-being*
1550 *requires that physicians retain the joy in medicine while managing their*
1551 *own real life stresses. Self-care and responsibility to support other*
1552 *members of the health care team are important components of*
1553 *professionalism; they are also skills that must be modeled, learned, and*
1554 *nurtured in the context of other aspects of fellowship training.*
1555

1556 *Fellows and faculty members are at risk for burnout and depression.*
1557 *Programs, in partnership with their Sponsoring Institutions, have the same*
1558 *responsibility to address well-being as other aspects of resident*
1559 *competence. Physicians and all members of the health care team share*
1560 *responsibility for the well-being of each other. For example, a culture which*
1561 *encourages covering for colleagues after an illness without the expectation*
1562 *of reciprocity reflects the ideal of professionalism. A positive culture in a*
1563 *clinical learning environment models constructive behaviors, and prepares*
1564 *fellows with the skills and attitudes needed to thrive throughout their*
1565 *careers.*
1566

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

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

1567

1568 **VI.C.1.** **The responsibility of the program, in partnership with the**
1569 **Sponsoring Institution, to address well-being must include:**

1570
1571 **VI.C.1.a)** **efforts to enhance the meaning that each fellow finds in the**
1572 **experience of being a physician, including protecting time**
1573 **with patients, minimizing non-physician obligations,**
1574 **providing administrative support, promoting progressive**
1575 **autonomy and flexibility, and enhancing professional**
1576 **relationships;** (Core)

1577
1578 **VI.C.1.b)** **attention to scheduling, work intensity, and work**
1579 **compression that impacts fellow well-being;** (Core)

1580
1581 **VI.C.1.c)** **evaluating workplace safety data and addressing the safety of**
1582 **fellows and faculty members;** (Core)
1583

Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that monitor and enhance fellow and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after adverse events.

1584
1585 **VI.C.1.d)** **policies and programs that encourage optimal fellow and**
1586 **faculty member well-being; and,** (Core)
1587

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.

1588
1589 **VI.C.1.d).(1)** **Fellows must be given the opportunity to attend**
1590 **medical, mental health, and dental care appointments,**
1591 **including those scheduled during their working hours.**
1592 (Core)
1593

Background and Intent: The intent of this requirement is to ensure that fellows have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Fellows must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

1594
1595 **VI.C.1.e)** **attention to fellow and faculty member burnout, depression,**
1596 **and substance use disorder. The program, in partnership with**
1597 **its Sponsoring Institution, must educate faculty members and**
1598 **fellows in identification of the symptoms of burnout,**
1599 **depression, and substance use disorder, including means to**
1600 **assist those who experience these conditions. Fellows and**
1601 **faculty members must also be educated to recognize those**
1602 **symptoms in themselves and how to seek appropriate care.**

1603
1604
1605

The program, in partnership with its Sponsoring Institution, must: ^(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>).

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

Background and Intent: Individuals experiencing burnout, depression, substance use disorder, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that fellows and faculty members are able to report their concerns when another fellow or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Fellows and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

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

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

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.

1624

1625 VI.C.2. There are circumstances in which fellows may be unable to attend
1626 work, including but not limited to fatigue, illness, family
1627 emergencies, and parental leave. Each program must allow an
1628 appropriate length of absence for fellows unable to perform their
1629 patient care responsibilities. ^(Core)
1630

1631 VI.C.2.a) The program must have policies and procedures in place to
1632 ensure coverage of patient care. ^(Core)
1633

1634 VI.C.2.b) These policies must be implemented without fear of negative
1635 consequences for the fellow who is or was unable to provide
1636 the clinical work. ^(Core)
1637

Background and Intent: Fellows may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.

1638
1639 VI.D. Fatigue Mitigation
1640

1641 VI.D.1. Programs must:

1642
1643 VI.D.1.a) educate all faculty members and fellows to recognize the
1644 signs of fatigue and sleep deprivation; ^(Core)
1645

1646 VI.D.1.b) educate all faculty members and fellows in alertness
1647 management and fatigue mitigation processes; and, ^(Core)
1648

1649 VI.D.1.c) encourage fellows to use fatigue mitigation processes to
1650 manage the potential negative effects of fatigue on patient
1651 care and learning. ^(Detail)
1652

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares fellows for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

This requirement emphasizes the importance of adequate rest before and after clinical responsibilities. Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

1653
1654 VI.D.2. Each program must ensure continuity of patient care, consistent
1655 with the program's policies and procedures referenced in VI.C.2–

1656 VI.C.2.b), in the event that a fellow may be unable to perform their
1657 patient care responsibilities due to excessive fatigue. ^(Core)

1658
1659 VI.D.3. The program, in partnership with its Sponsoring Institution, must
1660 ensure adequate sleep facilities and safe transportation options for
1661 fellows who may be too fatigued to safely return home. ^(Core)

1662
1663 VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

1664
1665 VI.E.1. Clinical Responsibilities

1666
1667 The clinical responsibilities for each fellow must be based on PGY
1668 level, patient safety, fellow ability, severity and complexity of patient
1669 illness/condition, and available support services. ^(Core)

1670

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on fellows. Faculty members and program directors need to make sure fellows function in an environment that has safe patient care and a sense of fellow well-being. Some Review Committees have addressed this by setting limits on patient admissions, and it is an essential responsibility of the program director to monitor fellow workload. Workload should be distributed among the fellow team and interdisciplinary teams to minimize work compression.

1671
1672 VI.E.2. Teamwork

1673
1674 Fellows must care for patients in an environment that maximizes
1675 communication. This must include the opportunity to work as a
1676 member of effective interprofessional teams that are appropriate to
1677 the delivery of care in the subspecialty and larger health system.
1678 ^(Core)

1679
1680 VI.E.3. Transitions of Care

1681
1682 VI.E.3.a) Programs must design clinical assignments to optimize
1683 transitions in patient care, including their safety, frequency,
1684 and structure. ^(Core)

1685
1686 VI.E.3.b) Programs, in partnership with their Sponsoring Institutions,
1687 must ensure and monitor effective, structured hand-over
1688 processes to facilitate both continuity of care and patient
1689 safety. ^(Core)

1690
1691 VI.E.3.c) Programs must ensure that fellows are competent in
1692 communicating with team members in the hand-over process.
1693 ^(Outcome)

1694
1695 VI.E.3.d) Programs and clinical sites must maintain and communicate
1696 schedules of attending physicians and fellows currently
1697 responsible for care. ^(Core)

1698

1699 VI.E.3.e) Each program must ensure continuity of patient care,
1700 consistent with the program’s policies and procedures
1701 referenced in VI.C.2-VI.C.2.b), in the event that a fellow may
1702 be unable to perform their patient care responsibilities due to
1703 excessive fatigue or illness, or family emergency. ^(Core)
1704

1705 VI.F. Clinical Experience and Education

1706
1707 *Programs, in partnership with their Sponsoring Institutions, must design*
1708 *an effective program structure that is configured to provide fellows with*
1709 *educational and clinical experience opportunities, as well as reasonable*
1710 *opportunities for rest and personal activities.*
1711

Background and Intent: In the new requirements, the terms “clinical experience and education,” “clinical and educational work,” and “clinical and educational work hours” replace the terms “duty hours,” “duty periods,” and “duty.” These changes have been made in response to concerns that the previous use of the term “duty” in reference to number of hours worked may have led some to conclude that fellows’ duty to “clock out” on time superseded their duty to their patients.

1712
1713 VI.F.1. Maximum Hours of Clinical and Educational Work per Week

1714
1715 Clinical and educational work hours must be limited to no more than
1716 80 hours per week, averaged over a four-week period, inclusive of all
1717 in-house clinical and educational activities, clinical work done from
1718 home, and all moonlighting. ^(Core)
1719

Background and Intent: Programs and fellows have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing fellows to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.

Scheduling

While the ACGME acknowledges that, on rare occasions, a fellow may work in excess of 80 hours in a given week, all programs and fellows utilizing this flexibility will be required to adhere to the 80-hour maximum weekly limit when averaged over a four-week period. Programs that regularly schedule fellows to work 80 hours per week and still permit fellows to remain beyond their scheduled work period are likely to exceed the 80-hour maximum, which would not be in substantial compliance with the requirement. These programs should adjust schedules so that fellows are scheduled to work fewer than 80 hours per week, which would allow fellows to remain beyond their scheduled work period when needed without violating the 80-hour requirement. Programs may wish to consider using night float and/or making adjustments to the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.

Oversight

With increased flexibility introduced into the Requirements, programs permitting this flexibility will need to account for the potential for fellows to remain beyond their assigned work periods when developing schedules, to avoid exceeding the 80-hour

maximum weekly limit, averaged over four weeks. The ACGME Review Committees will strictly monitor and enforce compliance with the 80-hour requirement. Where violations of the 80-hour requirement are identified, programs will be subject to citation and at risk for an adverse accreditation action.

Work from Home

While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that fellows are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The new requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work fellows choose to do from home. The requirement provides flexibility for fellows to do this while ensuring that the time spent by fellows completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Fellow decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the fellow's supervisor. In such circumstances, fellows should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a fellow spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the fellow need to report that time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by fellows. The new requirements are not an attempt to micromanage this process. Fellows are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual fellow. Programs will need to factor in time fellows are spending on clinical work at home when schedules are developed to ensure that fellows are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that fellows report their time from home and that schedules are structured to ensure that fellows are not working in excess of 80 hours per week, averaged over four weeks.

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

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

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

1731 VI.F.2.b).(1) There may be circumstances when fellows choose to
1732 stay to care for their patients or return to the hospital
1733 with fewer than eight hours free of clinical experience
1734 and education. This must occur within the context of
1735 the 80-hour and the one-day-off-in-seven
1736 requirements. ^(Detail)
1737

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

1738 VI.F.2.c) Fellows must have at least 14 hours free of clinical work and
1739 education after 24 hours of in-house call. ^(Core)
1740
1741

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.

1742 VI.F.2.d) Fellows must be scheduled for a minimum of one day in
1743 seven free of clinical work and required education (when
1744 averaged over four weeks). At-home call cannot be assigned
1745 on these free days. ^(Core)
1746
1747

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."

1748 VI.F.3. Maximum Clinical Work and Education Period Length

1749 VI.F.3.a) Clinical and educational work periods for fellows must not
1750 exceed 24 hours of continuous scheduled clinical
1751 assignments. ^(Core)
1752
1753
1754

1755 VI.F.3.a).(1) Up to four hours of additional time may be used for
1756 activities related to patient safety, such as providing
1757 effective transitions of care, and/or fellow education.
1758 (Core)

1759
1760 VI.F.3.a).(1).(a) Additional patient care responsibilities must not
1761 be assigned to a fellow during this time. (Core)
1762

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

1763
1764 VI.F.4. Clinical and Educational Work Hour Exceptions

1765 VI.F.4.a) In rare circumstances, after handing off all other
1766 responsibilities, a fellow, on their own initiative, may elect to
1767 remain or return to the clinical site in the following
1768 circumstances:
1769

1770
1771 VI.F.4.a).(1) to continue to provide care to a single severely ill or
1772 unstable patient; (Detail)

1773
1774 VI.F.4.a).(2) humanistic attention to the needs of a patient or
1775 family; or, (Detail)

1776
1777 VI.F.4.a).(3) to attend unique educational events. (Detail)

1778
1779 VI.F.4.b) These additional hours of care or education will be counted
1780 toward the 80-hour weekly limit. (Detail)
1781

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.

1782
1783 VI.F.4.c) A Review Committee may grant rotation-specific exceptions
1784 for up to 10 percent or a maximum of 88 clinical and
1785 educational work hours to individual programs based on a
1786 sound educational rationale.

1787
1788 The Review Committee for Diagnostic Radiology will not consider
1789 requests for exceptions to the 80-hour limit to the fellows' work

1790 week.

1791

1792 **VI.F.5. Moonlighting**

1793

1794 **VI.F.5.a) Moonlighting must not interfere with the ability of the fellow**
1795 **to achieve the goals and objectives of the educational**
1796 **program, and must not interfere with the fellow's fitness for**
1797 **work nor compromise patient safety. (Core)**

1798

1799 **VI.F.5.b) Time spent by fellows in internal and external moonlighting**
1800 **(as defined in the ACGME Glossary of Terms) must be**
1801 **counted toward the 80-hour maximum weekly limit. (Core)**

1802

Background and Intent: For additional clarification of the expectations related to moonlighting, please refer to the Common Program Requirement FAQs (available at <http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements>).

1803

1804 **VI.F.6. In-House Night Float**

1805

1806 **Night float must occur within the context of the 80-hour and one-**
1807 **day-off-in-seven requirements. (Core)**

1808

Background and Intent: The requirement for no more than six consecutive nights of night float was removed to provide programs with increased flexibility in scheduling.

1809

1810 **VI.F.7. Maximum In-House On-Call Frequency**

1811

1812 **Fellows must be scheduled for in-house call no more frequently than**
1813 **every third night (when averaged over a four-week period). (Core)**

1814

1815 **VI.F.8. At-Home Call**

1816

1817 **VI.F.8.a) Time spent on patient care activities by fellows on at-home**
1818 **call must count toward the 80-hour maximum weekly limit.**
1819 **The frequency of at-home call is not subject to the every-**
1820 **third-night limitation, but must satisfy the requirement for one**
1821 **day in seven free of clinical work and education, when**
1822 **averaged over four weeks. (Core)**

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1824 **VI.F.8.a).(1) At-home call must not be so frequent or taxing as to**
1825 **preclude rest or reasonable personal time for each**
1826 **fellow. (Core)**

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1828 **VI.F.8.b) Fellows are permitted to return to the hospital while on at-**
1829 **home call to provide direct care for new or established**
1830 **patients. These hours of inpatient patient care must be**
1831 **included in the 80-hour maximum weekly limit. (Detail)**

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Background and Intent: This requirement has been modified to specify that clinical work done from home when a fellow is taking at-home call must count toward the 80-hour

maximum weekly limit. This change acknowledges the often significant amount of time fellows devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in fellows routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

In their evaluation of fellowship programs, Review Committees will look at the overall impact of at-home call on fellow rest and personal time.

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

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

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

Osteopathic Recognition

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