ACGME Program Requirements for Graduate Medical Education in Pediatric Urology

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ACGME Program Requirements for Graduate Medical Education in Pediatric Urology

Common Program Requirements (Fellowship) are in BOLD

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

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

Introduction

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

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

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

Int.B. **Definition of Subspecialty**

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Fellowship education in pediatric urology consists of the diagnosis, management, and treatment of fetal, perinatal, childhood, pre-adolescent, and adolescent genitourinary and adrenal abnormalities and diseases, and the promotion of health with prevention of disease. This education includes experience with fetal and genetic evaluation; pediatric endocrinology; issues of renal disease, such as chronic renal insufficiency, and transplantation; congenital and acquired neurological diseases affecting the urinary tract, such as spina bifida and neurogenic bladder; treatment and management of congenital genitourinary abnormalities and reconstructive urology across all ages. Fellowship education in pediatric urology also includes scholarly activity to advance education, improve quality of care, and further the basic understanding of pediatric urologic disease through clinical outcome, health services, and laboratory-based research. (Core)*

Int.C. Length of Educational Program

The educational program in pediatric urology must be ~~12~~ 24 months in length. (Core)

I. Oversight

I.A. Sponsoring Institution

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

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

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

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

I.B. Participating Sites

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

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

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90		
91	I.B.1.a)	The program must be centered at a children's hospital or a medical center with pediatric medical, surgical, and imaging capabilities, and must be affiliated with an ACGME-accredited urology program. (Core)
95		
96	**I.B.2.**	**There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)**
100		
101	**I.B.2.a)**	**The PLA must:**
102		
103	**I.B.2.a).(1)**	**be renewed at least every 10 years; and, (Core)**
104		
105	**I.B.2.a).(2)**	**be approved by the designated institutional official (DIO). (Core)**
107		
108	**I.B.3.**	**The program must monitor the clinical learning and working environment at all participating sites. (Core)**
110		
111	**I.B.3.a)**	**At each participating site there must be one faculty member, designated by the program director, who is accountable for fellow education for that site, in collaboration with the program director. (Core)**
115		

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**

116		
117	**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.B.5. ~~Assignments at participating sites must be for a minimum of one month to ensure a quality educational experience, and must provide sufficient opportunity for continuity of care. (Core)~~

I.B.6. The program director must be meaningfully involved in ~~any~~ all associated core urology residency programs. (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).

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) The program should have technologically-current and pediatric-specific diagnostic and treatment facilities, ~~such as~~ including body-imaging and urodynamics equipment, interventional radiology, and anesthesia and pain management suitable for the care of pediatric patients. (Core)

I.D.1.b) The program must ensure adequate space and equipment for the educational program, such as meeting rooms and classrooms, educational aides, and sufficient office space for fellows and staff members. (Core)

I.D.1.c) The program must have access to adequate research resources to support faculty members' and fellows' scholarly activities. (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)**

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162-164	**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.

167-169	**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).

172-173	**I.D.2.d)**	**security and safety measures appropriate to the participating site; and, (Core)**
175-176	**I.D.2.e)**	**accommodations for fellows with disabilities consistent with the Sponsoring Institution's policy. (Core)**
178-181	**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)**
183-184	**I.D.4.**	**The program's educational and clinical resources must be adequate to support the number of fellows appointed to the program. (Core)**
186-189	I.D.4.a)	The Sponsoring Institution must provide a sufficient volume and variety of pediatric urology experience to meet the needs of the fellows' education without compromising the quality of resident education in the core urology program. (Core)
191-196	I.D.4.b)	The program must have the following resources available for fellow education: a broad spectrum of urologic diseases; and a sufficient volume and broad variety of pediatric urology surgical procedures consisting of a minimum of 500 procedures per year and 2000 pediatric urologic outpatient visits per year, including urology subspecialty clinics. (Core)

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197
198 **I.E.** ***A fellowship program usually occurs in the context of many learners and***
199 ***other care providers and limited clinical resources. It should be structured***
200 ***to optimize education for all learners present.***
201
202 **I.E.1.** **Fellows should contribute to the education of residents in core**
203 **programs, if present.** **(Core)**
204

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.

205
206 **II. Personnel**
207
208 **II.A. Program Director**
209
210 **II.A.1.** **There must be one faculty member appointed as program director**
211 **with authority and accountability for the overall program, including**
212 **compliance with all applicable program requirements.** **(Core)**
213
214 **II.A.1.a)** **The Sponsoring Institution's Graduate Medical Education**
215 **Committee (GMEC) must approve a change in program**
216 **director.** **(Core)**
217
218 **II.A.1.b)** **Final approval of the program director resides with the**
219 **Review Committee.** **(Core)**
220

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

221
222 **II.A.2.** **The program director must be provided with support adequate for**
223 **administration of the program based upon its size and configuration.**
224 **(Core)**
225
226 II.A.2.a) At a minimum, the program director must be provided with the
227 salary support required to devote 10 percent FTE of non-clinical
228 time to the administration of the program. (Core)
229

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

"Administrative time" is defined as non-clinical time spent meeting the responsibilities of

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the program director as detailed in requirements II.A.4.-II.A.4.a).(16).

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

230
231 **II.A.3.** **Qualifications of the program director:**
232
233 **II.A.3.a)** **must include subspecialty expertise and qualifications**
234 **acceptable to the Review Committee; and,** (Core)
235
236 **II.A.3.b)** **must include current certification in the subspecialty for**
237 **which they are the program director by the American Board**
238 **of** Urology **or subspecialty qualifications that are acceptable**
239 **to the Review Committee.** (Core)
240
241 [Note that while the Common Program Requirements deem
242 certification by a certifying board of the American Osteopathic
243 Association (AOA) acceptable, there is no AOA board that offers
244 certification in this subspecialty]
245
246 **II.A.4.** **Program Director Responsibilities**
247
248 **The program director must have responsibility, authority, and**
249 **accountability for: administration and operations; teaching and**
250 **scholarly activity; fellow recruitment and selection, evaluation, and**
251 **promotion of fellows, and disciplinary action; supervision of fellows;**
252 **and fellow education in the context of patient care.** (Core)
253
254 **II.A.4.a)** **The program director must:**
255
256 **II.A.4.a).(1)** **be a role model of professionalism;** (Core)
257

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.

258
259 **II.A.4.a).(2)** **design and conduct the program in a fashion**
260 **consistent with the needs of the community, the**
261 **mission(s) of the Sponsoring Institution, and the**
262 **mission(s) of the program;** (Core)
263

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.

264
265 **II.A.4.a).(3)** **administer and maintain a learning environment**
266 **conducive to educating the fellows in each of the**
267 **ACGME Competency domains;** (Core)
268

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.

269
270 **II.A.4.a).(4)** **develop and oversee a process to evaluate candidates**
271 **prior to approval as program faculty members for**
272 **participation in the fellowship program education and**
273 **at least annually thereafter, as outlined in V.B.;** (Core)
274
275 **II.A.4.a).(5)** **have the authority to approve program faculty**
276 **members for participation in the fellowship program**
277 **education at all sites;** (Core)
278
279 **II.A.4.a).(6)** **have the authority to remove program faculty**
280 **members from participation in the fellowship program**
281 **education at all sites;** (Core)
282
283 **II.A.4.a).(7)** **have the authority to remove fellows from supervising**
284 **interactions and/or learning environments that do not**
285 **meet the standards of the program;** (Core)
286

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.

287
288 **II.A.4.a).(8)** **submit accurate and complete information required**
289 **and requested by the DIO, GMEC, and ACGME;** (Core)
290
291 **II.A.4.a).(9)** **provide applicants who are offered an interview with**
292 **information related to the applicant's eligibility for the**
293 **relevant subspecialty board examination(s);** (Core)
294
295 **II.A.4.a).(10)** **provide a learning and working environment in which**
296 **fellows have the opportunity to raise concerns and**
297 **provide feedback in a confidential manner as**

298 **appropriate, without fear of intimidation or retaliation;**
299 **(Core)**
300
301 **II.A.4.a).(11)** **ensure the program's compliance with the Sponsoring**
302 **Institution's policies and procedures related to**
303 **grievances and due process; (Core)**
304
305 **II.A.4.a).(12)** **ensure the program's compliance with the Sponsoring**
306 **Institution's policies and procedures for due process**
307 **when action is taken to suspend or dismiss, not to**
308 **promote, or not to renew the appointment of a fellow;**
309 **(Core)**
310

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.

311
312 **II.A.4.a).(13)** **ensure the program's compliance with the Sponsoring**
313 **Institution's policies and procedures on employment**
314 **and non-discrimination; (Core)**
315
316 **II.A.4.a).(13).(a)** **Fellows must not be required to sign a non-**
317 **competition guarantee or restrictive covenant.**
318 **(Core)**
319
320 **II.A.4.a).(14)** **document verification of program completion for all**
321 **graduating fellows within 30 days; (Core)**
322
323 **II.A.4.a).(15)** **provide verification of an individual fellow's**
324 **completion upon the fellow's request, within 30 days;**
325 **and, (Core)**
326

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.

327
328 **II.A.4.a).(16)** **obtain review and approval of the Sponsoring**
329 **Institution's DIO before submitting information or**
330 **requests to the ACGME, as required in the Institutional**
331 **Requirements and outlined in the ACGME Program**
332 **Director's Guide to the Common Program**
333 **Requirements. (Core)**
334
335 **II.B.** **Faculty**
336
337 ***Faculty members are a foundational element of graduate medical education***
338 ***– faculty members teach fellows how to care for patients. Faculty members***

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339 ***provide an important bridge allowing fellows to grow and become practice***
340 ***ready, ensuring that patients receive the highest quality of care. They are***
341 ***role models for future generations of physicians by demonstrating***
342 ***compassion, commitment to excellence in teaching and patient care,***
343 ***professionalism, and a dedication to lifelong learning. Faculty members***
344 ***experience the pride and joy of fostering the growth and development of***
345 ***future colleagues. The care they provide is enhanced by the opportunity to***
346 ***teach. By employing a scholarly approach to patient care, faculty members,***
347 ***through the graduate medical education system, improve the health of the***
348 ***individual and the population.***
349
350 ***Faculty members ensure that patients receive the level of care expected***
351 ***from a specialist in the field. They recognize and respond to the needs of***
352 ***the patients, fellows, community, and institution. Faculty members provide***
353 ***appropriate levels of supervision to promote patient safety. Faculty***
354 ***members create an effective learning environment by acting in a***
355 ***professional manner and attending to the well-being of the fellows and***
356 ***themselves.***
357

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

358
359 **II.B.1.** **For each participating site, there must be a sufficient number of**
360 **faculty members with competence to instruct and supervise all**
361 **fellows at that location.** **(Core)**
362
363 **II.B.2.** **Faculty members must:**
364
365 **II.B.2.a)** **be role models of professionalism;** **(Core)**
366
367 **II.B.2.b)** **demonstrate commitment to the delivery of safe, quality,**
368 **cost-effective, patient-centered care;** **(Core)**
369

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.

370
371 **II.B.2.c)** **demonstrate a strong interest in the education of fellows;** **(Core)**
372
373 **II.B.2.d)** **devote sufficient time to the educational program to fulfill**
374 **their supervisory and teaching responsibilities;** **(Core)**
375
376 **II.B.2.e)** **administer and maintain an educational environment**
377 **conducive to educating fellows;** **(Core)**
378
379 **II.B.2.f)** **regularly participate in organized clinical discussions,**
380 **rounds, journal clubs, and conferences; and,** **(Core)**
381

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382 **II.B.2.g)** **pursue faculty development designed to enhance their skills**
383 **at least annually.** (Core)
384

> **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.**

385
386 **II.B.3.** **Faculty Qualifications**
387
388 **II.B.3.a)** **Faculty members must have appropriate qualifications in**
389 **their field and hold appropriate institutional appointments.**
390 (Core)
391
392 **II.B.3.b)** **Subspecialty physician faculty members must:**
393
394 **II.B.3.b).(1)** **have current certification in the subspecialty by the**
395 **American Board of** Urology**, or possess qualifications**
396 **judged acceptable to the Review Committee.** (Core)
397
398 [Note that while the Common Program Requirements
399 deem certification by a certifying board of the AOA
400 acceptable, there is no AOA board that offers certification
401 in this subspecialty]
402
403 **II.B.3.c)** **Any non-physician faculty members who participate in**
404 **fellowship program education must be approved by the**
405 **program director.** (Core)
406

> **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.**

407
408 **II.B.3.d)** **Any other specialty physician faculty members must have**
409 **current certification in their specialty by the appropriate**
410 **American Board of Medical Specialties (ABMS) member**
411 **board or American Osteopathic Association (AOA) certifying**
412 **board, or possess qualifications judged acceptable to the**
413 **Review Committee.** (Core)
414
415 **II.B.4.** **Core Faculty**
416

417 **Core faculty members must have a significant role in the education**
418 **and supervision of fellows and must devote a significant portion of**
419 **their entire effort to fellow education and/or administration, and**
420 **must, as a component of their activities, teach, evaluate, and provide**
421 **formative feedback to fellows.** (Core)
422

Background and Intent: Core faculty members are critical to the success of fellow education. They support the program leadership in developing, implementing, and assessing curriculum and in assessing fellows' progress toward achievement of competence in the subspecialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program, including completion of the annual ACGME Faculty Survey.

423
424 **II.B.4.a)** **Core faculty members must be designated by the program**
425 **director.** (Core)
426
427 **II.B.4.b)** **Core faculty members must complete the annual ACGME**
428 **Faculty Survey.** (Core)
429
430 II.B.4.c) In addition to the program director, there must be a minimum of
431 one core pediatric urology faculty member for each pediatric
432 urology fellow. (Core)
433
434 **II.C. Program Coordinator**
435
436 **II.C.1. There must be a program coordinator.** (Core)
437
438 **II.C.2.** **The program coordinator must be provided with support adequate**
439 **for administration of the program based upon its size and**
440 **configuration.** (Core)
441

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)

> **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.**

III. Fellow Appointments

III.A. Eligibility Criteria

III.A.1. Eligibility Requirements – Fellowship Programs

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

> **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).**

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

III.A.1.b) Fellows must have successfully completed a urology residency in a program that satisfies the requirements in III.A.1. (Core)

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

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

III.C. Fellow Transfers

The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to

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acceptance of a transferring fellow, and Milestones evaluations upon matriculation. (Core)

III.C.1. ~~The transfer of a fellow from one program to another must be reported to the Review Committee.~~ ~~(Core)~~

IV. Educational Program

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

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

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

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

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

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

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

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

Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

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529
530 **IV.A.4.** **structured educational activities beyond direct patient care; and,**
531 **(Core)**
532

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.

533
534 **IV.A.5.** **advancement of fellows' knowledge of ethical principles**
535 **foundational to medical professionalism.** **(Core)**
536
537 **IV.B. ACGME Competencies**
538

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.

539
540 **IV.B.1.** **The program must integrate the following ACGME Competencies**
541 **into the curriculum:** **(Core)**
542
543 **IV.B.1.a)** **Professionalism**
544
545 **Fellows must demonstrate a commitment to professionalism**
546 **and an adherence to ethical principles.** **(Core)**
547
548 **IV.B.1.b)** **Patient Care and Procedural Skills**
549

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.

550
551 **IV.B.1.b).(1)** **Fellows must be able to provide patient care that is**
552 **compassionate, appropriate, and effective for the**
553 **treatment of health problems and the promotion of**
554 **health.** **(Core)**

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555
556 IV.B.1.b).(1).(a) Fellows must demonstrate competence in:
557
558 IV.B.1.b).(1).(a).(i) multidisciplinary management of
559 myelomeningocele and other neuropathic
560 bladder entities; (Core)
561
562 IV.B.1.b).(1).(a).(ii) multidisciplinary management of patients
563 with problems relating to sexual
564 development and medical aspects of
565 disorders of sex development (DSD) states;
566 (Core)
567
568 IV.B.1.b).(1).(a).(iii) multidisciplinary management of patients
569 with urologic tumors; (Core)
570
571 IV.B.1.b).(1).(a).(iv) multidisciplinary management of
572 nephrological and endocrinologic (adrenal)
573 disease; (Core)
574
575 IV.B.1.b).(1).(a).(v) multidisciplinary management of patients
576 with urologic trauma; (Core)
577
578 IV.B.1.b).(1).(a).(vi) management of genitourinary infections;
579 and, (Core)
580
581 IV.B.1.b).(1).(a).(vii) performance of prenatal and postnatal
582 genetic counseling for genitourinary tract
583 anomalies. (Core)
584
585 **IV.B.1.b).(2) Fellows must be able to perform all medical,**
586 **diagnostic, and surgical procedures considered**
587 **essential for the area of practice. (Core)**
588
589 IV.B.1.b).(2).(a) Fellows must demonstrate competence in:
590
591 IV.B.1.b).(2).(a).(i) all surgical aspects of pediatric urology that
592 must be documented by the fellow in the
593 ACGME Case Log System and reviewed by
594 the program director quarterly; (Core)
595
596 IV.B.1.b).(2).(a).(i).(a) All operative procedures in which the
597 pediatric urology fellow acts as a
598 surgeon, assistant, or teaching
599 assistant should be separately
600 documented. (Detail)†
601
602 IV.B.1.b).(2).(a).(i).(b) Each graduating fellow must perform
603 the minimum number of essential
604 operative cases and case categories

as established by the Review Committee. (Core)

IV.B.1.b).(2).(a).(ii) inpatient and outpatient consultations requiring management of pediatric urologic disease, with graded responsibility for patient care; (Core)

IV.B.1.b).(2).(a).(iii) imaging modalities used in the care of pediatric patients, including ultrasonography, fluoroscopy, computed tomography, magnetic resonance imaging, and nuclear scintigraphy; (Core)

IV.B.1.b).(2).(a).(iv) performance and evaluation of urodynamic studies; and, (Core)

IV.B.1.b).(2).(a).(v) pre- and post-operative management and treatment of severely ill neonates, children, pre-adolescents, and adolescents with genitourinary problems who require intensive medical care (i.e., neonatal or pediatric intensive care unit management). (Core)

IV.B.1.c) Medical Knowledge

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

IV.B.1.c).(1) Fellows must demonstrate the ability to integrate knowledge of the following into care of the pediatric urology patient: (Core)

IV.B.1.c).(1).(a) pediatric diseases and diagnoses, including: (Core)

IV.B.1.c).(1).(a).(i) endocrinology; (Core)

IV.B.1.c).(1).(a).(ii) nephrology; and, (Core)

IV.B.1.c).(1).(a).(iii) acute and chronic renal diseases. (Core)

IV.B.1.c).(1).(b) quality and patient safety measures; (Core)

IV.B.1.c).(1).(c) imaging of the pediatric genitourinary tract with a focus on radiation and imaging safety risks; and, (Core)

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655 IV.B.1.c).(1).(d) pharmacology and the safe use of commonly used
656 agents. (Core)
657
658 **IV.B.1.d) Practice-based Learning and Improvement**
659
660 **Fellows must demonstrate the ability to investigate and**
661 **evaluate their care of patients, to appraise and assimilate**
662 **scientific evidence, and to continuously improve patient care**
663 **based on constant self-evaluation and lifelong learning. (Core)**
664

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.

665
666 **IV.B.1.e) Interpersonal and Communication Skills**
667
668 **Fellows must demonstrate interpersonal and communication**
669 **skills that result in the effective exchange of information and**
670 **collaboration with patients, their families, and health**
671 **professionals. (Core)**
672
673 **IV.B.1.f) Systems-based Practice**
674
675 **Fellows must demonstrate an awareness of and**
676 **responsiveness to the larger context and system of health**
677 **care, including the social determinants of health, as well as**
678 **the ability to call effectively on other resources to provide**
679 **optimal health care. (Core)**
680
681 **IV.C. Curriculum Organization and Fellow Experiences**
682
683 **IV.C.1. The curriculum must be structured to optimize fellow educational**
684 **experiences, the length of these experiences, and supervisory**
685 **continuity. (Core)**
686
687 IV.C.1.a) Clinical experiences must be of sufficient length to ensure
688 continuity of patient care, ongoing supervision, longitudinal
689 relationships with faculty members, and meaningful assessment
690 and feedback. (Core)
691
692 **IV.C.2. The program must provide instruction and experience in pain**
693 **management if applicable for the subspecialty, including recognition**
694 **of the signs of addiction. (Core)**
695
696 IV.C.2.a) Fellows must demonstrate knowledge of safe use of medicine in
697 pediatric pain management. ~~(Outcome)‡~~(Core)

698
699 IV.C.3. The program must ensure that the educational program for each fellow is
700 allocated as follows:
701
702 IV.C.3.a) Clinical education must consist of at least 12 consecutive months
703 of clinical pediatric urology.; and, (Core)
704
705 IV.C.3.a).(1) Clinical pediatric urology rotations must be comprised of
706 surgical and clinic experiences that include pre-operative,
707 operative, and post-operative patient care. (Core)
708
709 IV.C.3.a).(2) Fellows must work in multidisciplinary teams to learn a
710 wide range of clinical pediatric urology. (Core)
711
712 IV.C.3.a).(3) Fellows should attend a minimum of four clinic sessions
713 per month. (Detail)
714
715 IV.C.3.b) up to 12 months of non-clinical pediatric urology education and/or
716 research consistent with the program aims, and at the discretion
717 of the program director. (Core)
718
719 IV.C.4. Didactic Conferences
720
721 IV.C.4.a) Didactic conferences must reflect patient evaluation and include:
722
723 IV.C.4.a).(1) morbidity and mortality; (Core)
724
725 IV.C.4.a).(2) multidisciplinary urological imaging review; and, (Core)
726
727 IV.C.4.a).(3) journal review. (Core)
728
729 IV.C.4.b) A faculty member must supervise each conference. (Core)
730
731 IV.C.4.c) Fellows must attend didactic conferences throughout the 24
732 months of education. (Core)
733
734 IV.C.4.d) A list of conferences must be maintained and must include the
735 date, conference topic, the name of the presenter(s), and the
736 names of the faculty members and fellows present at each. (Core)
737
738 **IV.D. Scholarship**
739
740 ***Medicine is both an art and a science. The physician is a humanistic***
741 ***scientist who cares for patients. This requires the ability to think critically,***
742 ***evaluate the literature, appropriately assimilate new knowledge, and***
743 ***practice lifelong learning. The program and faculty must create an***
744 ***environment that fosters the acquisition of such skills through fellow***
745 ***participation in scholarly activities as defined in the subspecialty-specific***
746 ***Program Requirements. Scholarly activities may include discovery,***
747 ***integration, application, and teaching.***
748

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

IV.D.1. Program Responsibilities

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

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

IV.D.2. Faculty Scholarly Activity

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

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

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

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

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790
791 **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)‡**
792
793
794
795
796
797
798
799
800 **IV.D.2.b).(2)** **peer-reviewed publication.** **(Outcome)**
801
802 **IV.D.3.** **Fellow Scholarly Activity**
803
804 IV.D.3.a) ~~Dedicated research time must not occur during the fellowship (i.e., accredited clinical year).~~ ~~(Core)~~
805
806
807 IV.D.3.b) ~~Fellows should participate in other forms of scholarly activity, such as manuscript preparation, lectures, teaching activities, abstracts, quality improvement projects, and research project preparation or project completion.~~ ~~(Detail)~~
808
809
810
811
812 IV.D.3.c) Each fellow must design and conduct a scholarly project, under the guidance of a designated faculty mentor, that results in at least one manuscript of publishable quality. (Core)
813
814
815
816 IV.D.3.c).(1) The scholarly project must be:
817
818 IV.D.3.c).(1).(a) related to the field of pediatric urology; and, (Core)
819
820 IV.D.3.c).(1).(b) hypothesis-driven basic, translational, clinical, or quality improvement research. (Core)
821
822
823 IV.D.3.c).(2) The fellow must be the lead on the scholarly project. (Core)
824
825 IV.D.3.d) The fellow and the faculty mentor must develop a written Individualized Scholarly Activity Plan (ISAP) for the scholarly project. (Core)
826
827
828
829 IV.D.3.d).(1) At a minimum, the ISAP must be completed two months before the fellow initiates the scholarly project. (Core)
830
831
832 IV.D.3.d).(2) The ISAP must be approved by the program director, faculty mentor, and the Clinical Competency Committee as described in V.A.3.-V.A.3.b).(3). (Core)
833
834
835
836 IV.D.3.d).(3) The faculty mentor must review the fellow's progress on the ISAP at least quarterly and provide written feedback to the fellow. (Core)
837
838
839

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840 IV.D.3.d).(3).(a) The program director and members of the Clinical Competency Committee must receive a copy of the faculty mentor's feedback. (Core)

844 IV.D.3.d).(4) The Clinical Competency Committee must monitor the fellow's progress on the ISAP at least twice per year. (Core)

847 IV.D.3.d).(5) Prior to completion of the fellowship, each fellow must:

849 IV.D.3.d).(5).(a) give an oral presentation of the scholarly project to the program director, faculty mentor, members of the Clinical Competency Committee, other faculty members, and other learners; and, (Core)

854 IV.D.3.d).(5).(b) submit the manuscript to a peer-reviewed journal. (Core)

857 **IV.E.** ***Fellowship programs may assign fellows to engage in the independent practice of their core specialty during their fellowship program.***

860 **IV.E.1.** **If programs permit their fellows to utilize the independent practice option, it must not exceed 20 percent of their time per week or 10 weeks of an academic year. (Core)**

864 IV.E.1.a) While pediatric urology programs are permitted to utilize independent practice in general urology, this must not exceed 10 percent of fellows' time per week, averaged over four weeks, up to a maximum of 24 hours per month. (Core)

868

Background and Intent: Fellows who have previously completed residency programs have demonstrated sufficient competence to enter autonomous practice within their core specialty. This option is designed to enhance fellows' maturation and competence in their core specialty. This enables fellows to occupy a dual role in the health system: as learners in their subspecialty, and as credentialed practitioners in their core specialty. Hours worked in independent practice during fellowship still fall under the clinical and educational work hour limits. See Program Director Guide for more details.

869

870 Specialty-Specific Background and Intent: Fellows must limit independent practice to general urology. General urologic surgical care of pediatric patients includes circumcision/revisions, cystoscopy/ureteroscopy in adolescents, meatoplasty, simple orchidopexy, and testicular torsion treatment.

875 V. Evaluation

877 V.A. Fellow Evaluation

879 V.A.1. Feedback and Evaluation

880

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower fellows to

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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.

881
882 **V.A.1.a)** **Faculty members must directly observe, evaluate, and**
883 **frequently provide feedback on fellow performance during**
884 **each rotation or similar educational assignment.** (Core)
885

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.

886
887 **V.A.1.b)** **Evaluation must be documented at the completion of the**
888 **assignment.** (Core)
889
890 **V.A.1.b).(1)** **For block rotations of greater than three months in**
891 **duration, evaluation must be documented at least**
892 **every three months.** (Core)
893
894 **V.A.1.b).(2)** **Longitudinal experiences such as continuity clinic in**
895 **the context of other clinical responsibilities must be**
896 **evaluated at least every three months and at**
897 **completion.** (Core)
898

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899 **V.A.1.c)** **The program must provide an objective performance**
900 **evaluation based on the Competencies and the subspecialty-**
901 **specific Milestones, and must:** (Core)
902
903 **V.A.1.c).(1)** **use multiple evaluators (e.g., faculty members, peers,**
904 **patients, self, and other professional staff members);**
905 **and,** (Core)
906
907 **V.A.1.c).(2)** **provide that information to the Clinical Competency**
908 **Committee for its synthesis of progressive fellow**
909 **performance and improvement toward unsupervised**
910 **practice.** (Core)
911

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.

912
913 **V.A.1.d)** **The program director or their designee, with input from the**
914 **Clinical Competency Committee, must:**
915
916 **V.A.1.d).(1)** **meet with and review with each fellow their**
917 **documented semi-annual evaluation of performance,**
918 **including progress along the subspecialty-specific**
919 **Milestones.** (Core)
920
921 **V.A.1.d).(2)** **assist fellows in developing individualized learning**
922 **plans to capitalize on their strengths and identify areas**
923 **for growth; and,** (Core)
924
925 **V.A.1.d).(3)** **develop plans for fellows failing to progress, following**
926 **institutional policies and procedures.** (Core)
927

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**

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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.

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

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

V.A.2. **Final Evaluation**

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

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

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

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

V.A.2.a).(2).(b) **verify that the fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice;** **(Core)**

V.A.2.a).(2).(c) **consider recommendations from the Clinical Competency Committee; and,** **(Core)**

V.A.2.a).(2).(d) **be shared with the fellow upon completion of the program.** **(Core)**

V.A.3. **A Clinical Competency Committee must be appointed by the program director.** **(Core)**

V.A.3.a) **At a minimum the Clinical Competency Committee must include three members, at least one of whom is a core faculty member. Members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows.** **(Core)**

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974 **V.A.3.b)** **The Clinical Competency Committee must:**
975
976 **V.A.3.b).(1)** **review all fellow evaluations at least semi-annually;**
977 **(Core)**
978
979 **V.A.3.b).(2)** **determine each fellow's progress on achievement of**
980 **the subspecialty-specific Milestones; and, (Core)**
981
982 **V.A.3.b).(3)** **meet prior to the fellows' semi-annual evaluations and**
983 **advise the program director regarding each fellow's**
984 **progress. (Core)**
985
986 **V.B.** **Faculty Evaluation**
987
988 **V.B.1.** **The program must have a process to evaluate each faculty**
989 **member's performance as it relates to the educational program at**
990 **least annually. (Core)**
991

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.

992
993 **V.B.1.a)** **This evaluation must include a review of the faculty member's**
994 **clinical teaching abilities, engagement with the educational**
995 **program, participation in faculty development related to their**
996 **skills as an educator, clinical performance, professionalism,**
997 **and scholarly activities. (Core)**
998
999 **V.B.1.b)** **This evaluation must include written, confidential evaluations**
1000 **by the fellows. (Core)**
1001
1002 **V.B.2.** **Faculty members must receive feedback on their evaluations at least**
1003 **annually. (Core)**
1004

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1005 **V.B.3.** **Results of the faculty educational evaluations should be**
1006 **incorporated into program-wide faculty development plans.** (Core)
1007

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.

1008
1009 **V.C.** **Program Evaluation and Improvement**
1010
1011 **V.C.1.** **The program director must appoint the Program Evaluation**
1012 **Committee to conduct and document the Annual Program**
1013 **Evaluation as part of the program's continuous improvement**
1014 **process.** (Core)
1015
1016 **V.C.1.a)** **The Program Evaluation Committee must be composed of at**
1017 **least two program faculty members, at least one of whom is a**
1018 **core faculty member, and at least one fellow.** (Core)
1019
1020 **V.C.1.b)** **Program Evaluation Committee responsibilities must include:**
1021
1022 **V.C.1.b).(1)** **acting as an advisor to the program director, through**
1023 **program oversight;** (Core)
1024
1025 **V.C.1.b).(2)** **review of the program's self-determined goals and**
1026 **progress toward meeting them;** (Core)
1027
1028 **V.C.1.b).(3)** **guiding ongoing program improvement, including**
1029 **development of new goals, based upon outcomes;**
1030 **and,** (Core)
1031
1032 **V.C.1.b).(4)** **review of the current operating environment to identify**
1033 **strengths, challenges, opportunities, and threats as**
1034 **related to the program's mission and aims.** (Core)
1035

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.

1036
1037 **V.C.1.c)** **The Program Evaluation Committee should consider the**
1038 **following elements in its assessment of the program:**
1039
1040 **V.C.1.c).(1)** **curriculum;** (Core)
1041
1042 **V.C.1.c).(2)** **outcomes from prior Annual Program Evaluation(s);**
1043 (Core)

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1044
1045 **V.C.1.c).(3)** **ACGME letters of notification, including citations,**
1046 **Areas for Improvement, and comments;** (Core)
1047
1048 **V.C.1.c).(4)** **quality and safety of patient care;** (Core)
1049
1050 **V.C.1.c).(5)** **aggregate fellow and faculty:**
1051
1052 **V.C.1.c).(5).(a)** **well-being;** (Core)
1053
1054 **V.C.1.c).(5).(b)** **recruitment and retention;** (Core)
1055
1056 **V.C.1.c).(5).(c)** **workforce diversity;** (Core)
1057
1058 **V.C.1.c).(5).(d)** **engagement in quality improvement and patient**
1059 **safety;** (Core)
1060
1061 **V.C.1.c).(5).(e)** **scholarly activity;** (Core)
1062
1063 **V.C.1.c).(5).(f)** **ACGME Resident/Fellow and Faculty Surveys**
1064 **(where applicable); and,** (Core)
1065
1066 **V.C.1.c).(5).(g)** **written evaluations of the program.** (Core)
1067
1068 **V.C.1.c).(6)** **aggregate fellow:**
1069
1070 **V.C.1.c).(6).(a)** **achievement of the Milestones;** (Core)
1071
1072 **V.C.1.c).(6).(b)** **in-training examinations (where applicable);**
1073 (Core)
1074
1075 **V.C.1.c).(6).(c)** **board pass and certification rates; and,** (Core)
1076
1077 **V.C.1.c).(6).(d)** **graduate performance.** (Core)
1078
1079 **V.C.1.c).(7)** **aggregate faculty:**
1080
1081 **V.C.1.c).(7).(a)** **evaluation; and,** (Core)
1082
1083 **V.C.1.c).(7).(b)** **professional development** (Core)
1084
1085 **V.C.1.d)** **The Program Evaluation Committee must evaluate the**
1086 **program's mission and aims, strengths, areas for**
1087 **improvement, and threats.** (Core)
1088
1089 **V.C.1.e)** **The annual review, including the action plan, must:**
1090
1091 **V.C.1.e).(1)** **be distributed to and discussed with the members of**
1092 **the teaching faculty and the fellows; and,** (Core)
1093
1094 **V.C.1.e).(2)** **be submitted to the DIO.** (Core)

1095
1096 **V.C.2.** **The program must participate in a Self-Study prior to its 10-Year**
1097 **Accreditation Site Visit.** (Core)
1098
1099 **V.C.2.a)** **A summary of the Self-Study must be submitted to the DIO.**
1100 (Core)
1101

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.

1102
1103 **V.C.3.** ***One goal of ACGME-accredited education is to educate physicians***
1104 ***who seek and achieve board certification. One measure of the***
1105 ***effectiveness of the educational program is the ultimate pass rate.***
1106
1107 ***The program director should encourage all eligible program***
1108 ***graduates to take the certifying examination offered by the***
1109 ***applicable American Board of Medical Specialties (ABMS) member***
1110 ***board or American Osteopathic Association (AOA) certifying board.***
1111
1112 **V.C.3.a)** **For subspecialties in which the ABMS member board and/or**
1113 **AOA certifying board offer(s) an annual written exam, in the**
1114 **preceding three years, the program's aggregate pass rate of**
1115 **those taking the examination for the first time must be higher**
1116 **than the bottom fifth percentile of programs in that**
1117 **subspecialty.** (Outcome)
1118
1119 **V.C.3.b)** **For subspecialties in which the ABMS member board and/or**
1120 **AOA certifying board offer(s) a biennial written exam, in the**
1121 **preceding six years, the program's aggregate pass rate of**
1122 **those taking the examination for the first time must be higher**
1123 **than the bottom fifth percentile of programs in that**
1124 **subspecialty.** (Outcome)
1125
1126 **V.C.3.c)** **For subspecialties in which the ABMS member board and/or**
1127 **AOA certifying board offer(s) an annual oral exam, in the**
1128 **preceding three years, the program's aggregate pass rate of**
1129 **those taking the examination for the first time must be higher**
1130 **than the bottom fifth percentile of programs in that**
1131 **subspecialty.** (Outcome)
1132
1133 **V.C.3.d)** **For subspecialties in which the ABMS member board and/or**
1134 **AOA certifying board offer(s) a biennial oral exam, in the**

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1135 **preceding six years, the program's aggregate pass rate of**
1136 **those taking the examination for the first time must be higher**
1137 **than the bottom fifth percentile of programs in that**
1138 **subspecialty.** (Outcome)
1139
1140 **V.C.3.e)** **For each of the exams referenced in V.C.3.a)-d), any program**
1141 **whose graduates over the time period specified in the**
1142 **requirement have achieved an 80 percent pass rate will have**
1143 **met this requirement, no matter the percentile rank of the**
1144 **program for pass rate in that subspecialty.** (Outcome)
1145

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.

1146
1147 **V.C.3.f)** **Programs must report, in ADS, board certification status**
1148 **annually for the cohort of board-eligible fellows that**
1149 **graduated seven years earlier.** (Core)
1150

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.

1151
1152 **VI. The Learning and Working Environment**
1153
1154 ***Fellowship education must occur in the context of a learning and working***
1155 ***environment that emphasizes the following principles:***
1156
1157 - ***Excellence in the safety and quality of care rendered to patients by fellows***
1158 ***today***
1159

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1160 • ***Excellence in the safety and quality of care rendered to patients by today's fellows in their future practice***
1161
1162
1163 • ***Excellence in professionalism through faculty modeling of:***
1164
1165 o ***the effacement of self-interest in a humanistic environment that supports the professional development of physicians***
1166
1167
1168 o ***the joy of curiosity, problem-solving, intellectual rigor, and discovery***
1169
1170 • ***Commitment to the well-being of the students, residents, fellows, faculty members, and all members of the health care team***
1171
1172

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.

1173
1174 **VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability**
1175
1176 **VI.A.1. Patient Safety and Quality Improvement**
1177
1178 ***All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare fellows to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by fellows who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.***
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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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1236
1237 **VI.A.1.a).(3).(a)** **Residents, fellows, faculty members, and other clinical staff members must:**
1238
1239
1240 **VI.A.1.a).(3).(a).(i)** **know their responsibilities in reporting patient safety events at the clinical site;** **(Core)**
1241
1242
1243
1244 **VI.A.1.a).(3).(a).(ii)** **know how to report patient safety events, including near misses, at the clinical site; and,** **(Core)**
1245
1246
1247
1248 **VI.A.1.a).(3).(a).(iii)** **be provided with summary information of their institution's patient safety reports.** **(Core)**
1249
1250
1251
1252 **VI.A.1.a).(3).(b)** **Fellows must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.** **(Core)**
1253
1254
1255
1256
1257
1258
1259 **VI.A.1.a).(4)** **Fellow Education and Experience in Disclosure of Adverse Events**
1260
1261
1262 ***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.***
1263
1264
1265
1266
1267
1268 **VI.A.1.a).(4).(a)** **All fellows must receive training in how to disclose adverse events to patients and families.** **(Core)**
1269
1270
1271
1272 **VI.A.1.a).(4).(b)** **Fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated.** **(Detail)**
1273
1274
1275
1276 **VI.A.1.b)** **Quality Improvement**
1277
1278 **VI.A.1.b).(1)** **Education in Quality Improvement**
1279
1280 ***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.***
1281
1282
1283
1284

1285 **VI.A.1.b).(1).(a)** **Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities.** (Core)

1289 **VI.A.1.b).(2)** **Quality Metrics**

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

1295 **VI.A.1.b).(2).(a)** **Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations.** (Core)

1299 **VI.A.1.b).(3)** **Engagement in Quality Improvement Activities**

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

1305 **VI.A.1.b).(3).(a)** **Fellows must have the opportunity to participate in interprofessional quality improvement activities.** (Core)

1309 **VI.A.1.b).(3).(a).(i)** **This should include activities aimed at reducing health care disparities.** (Detail)

1312 **VI.A.2.** **Supervision and Accountability**

1314 **VI.A.2.a)** ***Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.***

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

1329 **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)

1336 **VI.A.2.a).(1).(a)** **This information must be available to fellows, faculty members, other members of the health care team, and patients.** **(Core)**

1340 **VI.A.2.a).(1).(b)** **Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.** **(Core)**

1344 **VI.A.2.b)** ***Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the appropriate availability of the supervising faculty member or fellow, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback.***

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

1356 **VI.A.2.b).(1)** **The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.** **(Core)**

1363 **VI.A.2.b).(2)** **The program must define when physical presence of a supervising physician is required.** **(Core)**

1366 **VI.A.2.c)** **Levels of Supervision**

1368 **To promote appropriate fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:** **(Core)**

1372 **VI.A.2.c).(1)** **Direct Supervision:**

1374 **VI.A.2.c).(1).(a)** **the supervising physician is physically present with the fellow during the key portions of the patient interaction.** **(Core)**

1378 **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)

1384 **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)

1388 **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)

1393 **VI.A.2.d).(1)** **The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones.** (Core)

1397 **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)

1402 **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)

1408 **VI.A.2.e)** **Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s).** (Core)

1412 **VI.A.2.e).(1)** **Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence.** (Outcome)

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

1418 **VI.A.2.f)** **Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each fellow and to delegate to the fellow the appropriate level of patient care authority and responsibility.** (Core)

1423 **VI.B. Professionalism**

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1425 **VI.B.1. Programs, in partnership with their Sponsoring Institutions, must**
1426 **educate fellows and faculty members concerning the professional**
1427 **responsibilities of physicians, including their obligation to be**
1428 **appropriately rested and fit to provide the care required by their**
1429 **patients.** (Core)
1430
1431 **VI.B.2. The learning objectives of the program must:**
1432
1433 **VI.B.2.a) be accomplished through an appropriate blend of supervised**
1434 **patient care responsibilities, clinical teaching, and didactic**
1435 **educational events;** (Core)
1436
1437 **VI.B.2.b) be accomplished without excessive reliance on fellows to**
1438 **fulfill non-physician obligations; and,** (Core)
1439

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.

1440
1441 **VI.B.2.c) ensure manageable patient care responsibilities.** (Core)
1442

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.

1443
1444 **VI.B.3. The program director, in partnership with the Sponsoring Institution,**
1445 **must provide a culture of professionalism that supports patient**
1446 **safety and personal responsibility.** (Core)
1447
1448 **VI.B.4. Fellows and faculty members must demonstrate an understanding**
1449 **of their personal role in the:**
1450
1451 **VI.B.4.a) provision of patient- and family-centered care;** (Outcome)
1452
1453 **VI.B.4.b) safety and welfare of patients entrusted to their care,**
1454 **including the ability to report unsafe conditions and adverse**
1455 **events;** (Outcome)
1456

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

1457
1458 **VI.B.4.c)** **assurance of their fitness for work, including:** (Outcome)
1459

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.

1460
1461 **VI.B.4.c).(1)** **management of their time before, during, and after**
1462 **clinical assignments; and,** (Outcome)
1463
1464 **VI.B.4.c).(2)** **recognition of impairment, including from illness,**
1465 **fatigue, and substance use, in themselves, their peers,**
1466 **and other members of the health care team.** (Outcome)
1467
1468 **VI.B.4.d)** **commitment to lifelong learning;** (Outcome)
1469
1470 **VI.B.4.e)** **monitoring of their patient care performance improvement**
1471 **indicators; and,** (Outcome)
1472
1473 **VI.B.4.f)** **accurate reporting of clinical and educational work hours,**
1474 **patient outcomes, and clinical experience data.** (Outcome)
1475
1476 **VI.B.5.** **All fellows and faculty members must demonstrate responsiveness**
1477 **to patient needs that supersedes self-interest. This includes the**
1478 **recognition that under certain circumstances, the best interests of**
1479 **the patient may be served by transitioning that patient's care to**
1480 **another qualified and rested provider.** (Outcome)
1481
1482 **VI.B.6.** **Programs, in partnership with their Sponsoring Institutions, must**
1483 **provide a professional, equitable, respectful, and civil environment**
1484 **that is free from discrimination, sexual and other forms of**
1485 **harassment, mistreatment, abuse, or coercion of students, fellows,**
1486 **faculty, and staff.** (Core)
1487
1488 **VI.B.7.** **Programs, in partnership with their Sponsoring Institutions, should**
1489 **have a process for education of fellows and faculty regarding**
1490 **unprofessional behavior and a confidential process for reporting,**
1491 **investigating, and addressing such concerns.** (Core)
1492
1493 **VI.C.** **Well-Being**
1494
1495 ***Psychological, emotional, and physical well-being are critical in the***
1496 ***development of the competent, caring, and resilient physician and require***
1497 ***proactive attention to life inside and outside of medicine. Well-being***

1498 ***requires that physicians retain the joy in medicine while managing their***
1499 ***own real life stresses. Self-care and responsibility to support other***
1500 ***members of the health care team are important components of***
1501 ***professionalism; they are also skills that must be modeled, learned, and***
1502 ***nurtured in the context of other aspects of fellowship training.***
1503
1504 ***Fellows and faculty members are at risk for burnout and depression.***
1505 ***Programs, in partnership with their Sponsoring Institutions, have the same***
1506 ***responsibility to address well-being as other aspects of resident***
1507 ***competence. Physicians and all members of the health care team share***
1508 ***responsibility for the well-being of each other. For example, a culture which***
1509 ***encourages covering for colleagues after an illness without the expectation***
1510 ***of reciprocity reflects the ideal of professionalism. A positive culture in a***
1511 ***clinical learning environment models constructive behaviors, and prepares***
1512 ***fellows with the skills and attitudes needed to thrive throughout their***
1513 ***careers.***
1514

Background and Intent: The ACGME is committed to addressing physician well-being for individuals and as it relates to the learning and working environment. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians' ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and collaboration. Information regarding the ACGME's ongoing efforts in this area is available on the ACGME website. **As these efforts evolve, information will be shared with programs seeking to develop and/or strengthen their own well-being initiatives. In addition, there are many activities that programs can utilize now to assess and support physician well-being. These include culture of safety surveys, ensuring the availability of counseling services, and attention to the safety of the entire health care team.**

1515
1516 **VI.C.1.** **The responsibility of the program, in partnership with the**
1517 **Sponsoring Institution, to address well-being must include:**
1518
1519 **VI.C.1.a)** **efforts to enhance the meaning that each fellow finds in the**
1520 **experience of being a physician, including protecting time**
1521 **with patients, minimizing non-physician obligations,**
1522 **providing administrative support, promoting progressive**
1523 **autonomy and flexibility, and enhancing professional**
1524 **relationships;** **(Core)**
1525
1526 **VI.C.1.b)** **attention to scheduling, work intensity, and work**
1527 **compression that impacts fellow well-being;** **(Core)**
1528
1529 **VI.C.1.c)** **evaluating workplace safety data and addressing the safety of**
1530 **fellows and faculty members;** **(Core)**
1531

Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that

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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.

1532
1533 **VI.C.1.d)** **policies and programs that encourage optimal fellow and**
1534 **faculty member well-being; and,** (Core)
1535

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.

1536
1537 **VI.C.1.d).(1)** **Fellows must be given the opportunity to attend**
1538 **medical, mental health, and dental care appointments,**
1539 **including those scheduled during their working hours.**
1540 (Core)
1541

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.

1542
1543 **VI.C.1.e)** **attention to fellow and faculty member burnout, depression,**
1544 **and substance use disorder. The program, in partnership with**
1545 **its Sponsoring Institution, must educate faculty members and**
1546 **fellows in identification of the symptoms of burnout,**
1547 **depression, and substance use disorder, including means to**
1548 **assist those who experience these conditions. Fellows and**
1549 **faculty members must also be educated to recognize those**
1550 **symptoms in themselves and how to seek appropriate care.**
1551 **The program, in partnership with its Sponsoring Institution,**
1552 **must:** (Core)
1553

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance use disorder. Materials and more information are available on the Physician Well-being section of the ACGME website (http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being).

1554
1555 **VI.C.1.e).(1)** **encourage fellows and faculty members to alert the**
1556 **program director or other designated personnel or**
1557 **programs when they are concerned that another**
1558 **fellow, resident, or faculty member may be displaying**
1559 **signs of burnout, depression, a substance use**
1560 **disorder, suicidal ideation, or potential for violence;**
1561 (Core)
1562

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

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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.

1563
1564 **VI.C.1.e).(2)** **provide access to appropriate tools for self-screening;**
1565 **and,** (Core)
1566
1567 **VI.C.1.e).(3)** **provide access to confidential, affordable mental**
1568 **health assessment, counseling, and treatment,**
1569 **including access to urgent and emergent care 24**
1570 **hours a day, seven days a week.** (Core)
1571

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.

1572
1573 **VI.C.2.** **There are circumstances in which fellows may be unable to attend**
1574 **work, including but not limited to fatigue, illness, family**
1575 **emergencies, and parental leave. Each program must allow an**
1576 **appropriate length of absence for fellows unable to perform their**
1577 **patient care responsibilities.** (Core)
1578
1579 **VI.C.2.a)** **The program must have policies and procedures in place to**
1580 **ensure coverage of patient care.** (Core)
1581
1582 **VI.C.2.b)** **These policies must be implemented without fear of negative**
1583 **consequences for the fellow who is or was unable to provide**
1584 **the clinical work.** (Core)
1585

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.

1586
1587 **VI.D.** **Fatigue Mitigation**

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1588
1589 **VI.D.1.** **Programs must:**
1590
1591 **VI.D.1.a)** **educate all faculty members and fellows to recognize the**
1592 **signs of fatigue and sleep deprivation;** (Core)
1593
1594 **VI.D.1.b)** **educate all faculty members and fellows in alertness**
1595 **management and fatigue mitigation processes; and,** (Core)
1596
1597 **VI.D.1.c)** **encourage fellows to use fatigue mitigation processes to**
1598 **manage the potential negative effects of fatigue on patient**
1599 **care and learning.** (Detail)
1600

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.

1601
1602 **VI.D.2.** **Each program must ensure continuity of patient care, consistent**
1603 **with the program's policies and procedures referenced in VI.C.2–**
1604 **VI.C.2.b), in the event that a fellow may be unable to perform their**
1605 **patient care responsibilities due to excessive fatigue.** (Core)
1606
1607 **VI.D.3.** **The program, in partnership with its Sponsoring Institution, must**
1608 **ensure adequate sleep facilities and safe transportation options for**
1609 **fellows who may be too fatigued to safely return home.** (Core)
1610
1611 **VI.E.** **Clinical Responsibilities, Teamwork, and Transitions of Care**
1612
1613 **VI.E.1.** **Clinical Responsibilities**
1614
1615 **The clinical responsibilities for each fellow must be based on PGY**
1616 **level, patient safety, fellow ability, severity and complexity of patient**
1617 **illness/condition, and available support services.** (Core)
1618

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

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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.

1619
1620 **VI.E.2. Teamwork**
1621
1622 **Fellows must care for patients in an environment that maximizes**
1623 **communication. This must include the opportunity to work as a**
1624 **member of effective interprofessional teams that are appropriate to**
1625 **the delivery of care in the subspecialty and larger health system.**
1626 **(Core)**
1627
1628 **VI.E.3. Transitions of Care**
1629
1630 **VI.E.3.a) Programs must design clinical assignments to optimize**
1631 **transitions in patient care, including their safety, frequency,**
1632 **and structure. (Core)**
1633
1634 **VI.E.3.b) Programs, in partnership with their Sponsoring Institutions,**
1635 **must ensure and monitor effective, structured hand-over**
1636 **processes to facilitate both continuity of care and patient**
1637 **safety. (Core)**
1638
1639 **VI.E.3.c) Programs must ensure that fellows are competent in**
1640 **communicating with team members in the hand-over process.**
1641 **(Outcome)**
1642
1643 **VI.E.3.d) Programs and clinical sites must maintain and communicate**
1644 **schedules of attending physicians and fellows currently**
1645 **responsible for care. (Core)**
1646
1647 **VI.E.3.e) Each program must ensure continuity of patient care,**
1648 **consistent with the program's policies and procedures**
1649 **referenced in VI.C.2-VI.C.2.b), in the event that a fellow may**
1650 **be unable to perform their patient care responsibilities due to**
1651 **excessive fatigue or illness, or family emergency. (Core)**
1652
1653 **VI.F. Clinical Experience and Education**
1654
1655 ***Programs, in partnership with their Sponsoring Institutions, must design***
1656 ***an effective program structure that is configured to provide fellows with***
1657 ***educational and clinical experience opportunities, as well as reasonable***
1658 ***opportunities for rest and personal activities.***
1659

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

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number of hours worked may have led some to conclude that fellows' duty to "clock out" on time superseded their duty to their patients.

1660
1661 **VI.F.1. Maximum Hours of Clinical and Educational Work per Week**
1662
1663 **Clinical and educational work hours must be limited to no more than**
1664 **80 hours per week, averaged over a four-week period, inclusive of all**
1665 **in-house clinical and educational activities, clinical work done from**
1666 **home, and all moonlighting.** (Core)
1667

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

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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.

1668
1669 **VI.F.2. Mandatory Time Free of Clinical Work and Education**
1670
1671–1674 **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)**
1675
1676–1677 **VI.F.2.b) Fellows should have eight hours off between scheduled clinical work and education periods.** **(Detail)**
1678
1679–1684 **VI.F.2.b).(1) There may be circumstances when fellows choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.** **(Detail)**
1685

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.

1686

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1687 **VI.F.2.c)** **Fellows must have at least 14 hours free of clinical work and**
1688 **education after 24 hours of in-house call.** (Core)
1689

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.

1690
1691 **VI.F.2.d)** **Fellows must be scheduled for a minimum of one day in**
1692 **seven free of clinical work and required education (when**
1693 **averaged over four weeks). At-home call cannot be assigned**
1694 **on these free days.** (Core)
1695

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."

1696
1697 **VI.F.3.** **Maximum Clinical Work and Education Period Length**
1698
1699 **VI.F.3.a)** **Clinical and educational work periods for fellows must not**
1700 **exceed 24 hours of continuous scheduled clinical**
1701 **assignments.** (Core)
1702
1703 **VI.F.3.a).(1)** **Up to four hours of additional time may be used for**
1704 **activities related to patient safety, such as providing**
1705 **effective transitions of care, and/or fellow education.**
1706 (Core)
1707
1708 **VI.F.3.a).(1).(a)** **Additional patient care responsibilities must not**
1709 **be assigned to a fellow during this time.** (Core)
1710

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.

1711
1712 **VI.F.4.** **Clinical and Educational Work Hour Exceptions**
1713

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1714 **VI.F.4.a)** **In rare circumstances, after handing off all other responsibilities, a fellow, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:**

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

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

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

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

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.

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

The Review Committee for Urology will not consider requests for exceptions to the 80-hour weekly limit to the fellows' clinical and educational work.

VI.F.5. **Moonlighting**

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

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

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).

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1752 **VI.F.6. In-House Night Float**

1754 **Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.** (Core)

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.

1758 **VI.F.7. Maximum In-House On-Call Frequency**

1760 **Fellows must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).** (Core)

1763 **VI.F.8. At-Home Call**

1765 **VI.F.8.a) Time spent on patient care activities by fellows on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.** (Core)

1772 **VI.F.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow.** (Core)

1776 **VI.F.8.b) Fellows are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.** (Detail)

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.

1782 ***

1784 ***Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

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1787 [†]**Detail Requirements:** Statements that describe a specific structure, resource, or process, for
1788 achieving compliance with a Core Requirement. Programs and sponsoring institutions in
1789 substantial compliance with the Outcome Requirements may utilize alternative or innovative
1790 approaches to meet Core Requirements.
1791
1792 [‡]**Outcome Requirements:** Statements that specify expected measurable or observable
1793 attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their
1794 graduate medical education.
1795
1796 **Osteopathic Recognition**
1797 For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition
1798 Requirements also apply (www.acgme.org/OsteopathicRecognition).

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