

**ACGME Program Requirements for
Graduate Medical Education
in ~~Endovascular Surgical Neuroradiology~~Neuroendovascular
Intervention**

Proposed focused revision; posted for review and comment February 7, 2022. **Focused revision changes are shown in red. Please provide comments only on the changes shown in red.**

The revisions shown below in gray were posted for review and comment on December 21, 2020, as part of the major revision. The comments submitted on these changes will be reviewed by the ACGME Board in conjunction with this focused revision.

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1 **Proposed ACGME Program Requirements for Graduate Medical Education**
2 **in Neuroendovascular Intervention ~~Endovascular Surgical Neuroradiology~~**

3
4 **Common Program Requirements (Fellowship) are in BOLD**

5
6 Where applicable, text in italics describes the underlying philosophy of the requirements in that
7 section. These philosophic statements are not program requirements and are therefore not
8 citable.
9

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.

10
11 **Introduction**

12
13 **Int.A. *Fellowship is advanced graduate medical education beyond a core***
14 ***residency program for physicians who desire to enter more specialized***
15 ***practice. Fellowship-trained physicians serve the public by providing***
16 ***subspecialty care, which may also include core medical care, acting as a***
17 ***community resource for expertise in their field, creating and integrating***
18 ***new knowledge into practice, and educating future generations of***
19 ***physicians. Graduate medical education values the strength that a diverse***
20 ***group of physicians brings to medical care.***

21
22 ***Fellows who have completed residency are able to practice independently***
23 ***in their core specialty. The prior medical experience and expertise of***
24 ***fellows distinguish them from physicians entering into residency training.***
25 ***The fellow's care of patients within the subspecialty is undertaken with***
26 ***appropriate faculty supervision and conditional independence. Faculty***
27 ***members serve as role models of excellence, compassion,***
28 ***professionalism, and scholarship. The fellow develops deep medical***
29 ***knowledge, patient care skills, and expertise applicable to their focused***
30 ***area of practice. Fellowship is an intensive program of subspecialty clinical***
31 ***and didactic education that focuses on the multidisciplinary care of***
32 ***patients. Fellowship education is often physically, emotionally, and***
33 ***intellectually demanding, and occurs in a variety of clinical learning***
34 ***environments committed to graduate medical education and the well-being***
35 ***of patients, residents, fellows, faculty members, students, and all members***
36 ***of the health care team.***

37
38 ***In addition to clinical education, many fellowship programs advance***
39 ***fellows' skills as physician-scientists. While the ability to create new***
40 ***knowledge within medicine is not exclusive to fellowship-educated***
41 ***physicians, the fellowship experience expands a physician's abilities to***
42 ***pursue hypothesis-driven scientific inquiry that results in contributions to***
43 ***the medical literature and patient care. Beyond the clinical subspecialty***
44 ***expertise achieved, fellows develop mentored relationships built on an***
45 ***infrastructure that promotes collaborative research.***

46
47 **Int.B. Definition of Subspecialty**

48
49 Int.B.1. ~~Endovascular surgical neuroradiology~~ Neuroendovascular intervention is
50 a subspecialty that uses minimally invasive catheter-based technology,
51 radiologic imaging, and clinical expertise to diagnose and treat diseases
52 of the central nervous system, head, neck, and spine. The unique clinical
53 and invasive nature of this subspecialty requires special training and
54 skills.

55
56 ~~Int.B.2. In this subspecialty, the objective of training is to give fellows an~~
57 ~~organized, comprehensive, supervised, and full-time educational~~
58 ~~experience in endovascular surgical neuroradiology.~~

59
60 **Int.C. Length of Educational Program**

61
62 ~~The program shall offer one year of graduate medical education in endovascular~~
63 ~~surgical neuroradiology.~~ ^{(Core)*} The educational program in neuroendovascular
64 intervention must be at least 24 months in length. ^(Core)

65
66 **I. Oversight**

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68 **I.A. Sponsoring Institution**

69
70 *The Sponsoring Institution is the organization or entity that assumes the*
71 *ultimate financial and academic responsibility for a program of graduate*
72 *medical education consistent with the ACGME Institutional Requirements.*

73
74 *When the Sponsoring Institution is not a rotation site for the program, the*
75 *most commonly utilized site of clinical activity for the program is the*
76 *primary clinical site.*

77
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.

78
79 **I.A.1. The program must be sponsored by one ACGME-accredited**
80 **Sponsoring Institution.** ^(Core)

81
82 **I.B. Participating Sites**

83
84 *A participating site is an organization providing educational experiences or*
85 *educational assignments/rotations for fellows.*

86
87 **I.B.1. The program, with approval of its Sponsoring Institution, must**
88 **designate a primary clinical site.** ^(Core)

89

- 90 I.B.1.a) A program in ~~neuroendovascular intervention~~ endovascular
91 ~~surgical neuroradiology~~ must be jointly administered by programs
92 in ~~neurological surgery~~, diagnostic radiology, neurological surgery,
93 neuroradiology, and child neurology or neurology which are
94 accredited by the ACGME; these programs must be present within
95 the same primary clinical site. ^(Core)
96
- 97 I.B.1.a).(1) Exceptions to this requirement will be subject to the review
98 and approval, on a case-by-case basis, by the Review
99 Committees for Neurological Surgery, Neurology, and
100 Radiology. ~~The endovascular surgical neuroradiology~~
101 ~~program is not intended to replace or duplicate the~~
102 ~~ACGME-accredited program in neuroradiology.~~
103
- 104 **I.B.2. There must be a program letter of agreement (PLA) between the**
105 **program and each participating site that governs the relationship**
106 **between the program and the participating site providing a required**
107 **assignment.** ^(Core)
108
- 109 **I.B.2.a) The PLA must:**
110
- 111 **I.B.2.a).(1) be renewed at least every 10 years; and,** ^(Core)
112
- 113 **I.B.2.a).(2) be approved by the designated institutional official**
114 **(DIO).** ^(Core)
115
- 116 **I.B.3. The program must monitor the clinical learning and working**
117 **environment at all participating sites.** ^(Core)
118
- 119 **I.B.3.a) At each participating site there must be one faculty member,**
120 **designated by the program director, who is accountable for**
121 **fellow education for that site, in collaboration with the**
122 **program director.** ^(Core)
123

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

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

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

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

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

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

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

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I.D. Resources

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

I.D.1.a) Equipment and Facilities

I.D.1.a).(1) Modern imaging/procedure rooms and equipment must be available and ~~must~~ permit the performance of all neuroendovascular intervention ~~endovascular surgical neuroradiology~~ procedures. ^(Core)

I.D.1.a).(2) Rooms in which neuroendovascular intervention ~~endovascular surgical neuroradiology~~ procedures are performed ~~must should~~ be equipped with physiological monitoring and resuscitative equipment. ^(Core)

I.D.1.a).(2).(a) The following state-of-the-art equipment must be available:

I.D.1.a).(2).(a).(i) magnetic resonance imaging (MRI) scanner equipped with high-speed gradients, and perfusion capability; ^(Core)

I.D.1.a).(2).(a).(ii) computed tomography (CT) scanner (multi-detector) capable of CT angiography and CT perfusion; ^(Core)

- 165
166 I.D.1.a).(2).(a).(iii) biplane digital subtraction angiography with
167 roadmap and three-dimensional imaging
168 capability; (Core)
169
170 I.D.1.a).(2).(a).(iv) ultrasound; and, (Core)
171
172 I.D.1.a).(2).(a).(v) radiographic-fluoroscopic room(s). (Core)
173
174 I.D.1.a).(3) Facilities for storing catheters, guidewires, contrast
175 materials, embolic agents, and other supplies must be
176 adjacent to or within procedure rooms. (Core)
177
178 I.D.1.a).(4) There must be adequate space and facilities for image
179 display and interpretation, and for consultation with other
180 clinicians. (Core)
181
182 I.D.1.a).(5) The sites where neuroendovascular intervention
183 endovascular surgical neuroradiology training is conducted
184 must include inpatient, outpatient, emergency, and
185 intensive care facilities for direct fellow involvement in
186 providing comprehensive neuroendovascular intervention
187 endovascular surgical neuroradiology care. (Core)
188
189 I.D.1.a).(6) The Sponsoring Institution should provide laboratory
190 facilities to support research projects pertinent to
191 endovascular therapies. (Detail)†
192
193 **I.D.2. The program, in partnership with its Sponsoring Institution, must**
194 **ensure healthy and safe learning and working environments that**
195 **promote fellow well-being and provide for:** (Core)
196
197 **I.D.2.a) access to food while on duty;** (Core)
198
199 **I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available**
200 **and accessible for fellows with proximity appropriate for safe**
201 **patient care;** (Core)
202

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.

- 203
204 **I.D.2.c) clean and private facilities for lactation that have refrigeration**
205 **capabilities, with proximity appropriate for safe patient care;**
206 (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).

208

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

211

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

214

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

219

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

222

223 **I.D.4.a) ~~The program must ensure~~ ~~in order to ensure adequate training,~~**
 224 **~~the institution's~~ an adequate patient population ~~with~~ must have a**
 225 **diversity of illnesses from which fellows may obtain a broad**
 226 **experience in neuroendovascular intervention ~~endovascular~~**
 227 **~~surgical neuroradiology therapy can be obtained. (Core)~~**

228

229 **I.D.4.b) The case material should encompass a range of diseases,**
 230 **including: (Core)**

231

232 **I.D.4.b).(1) a minimum of 250 therapeutic neuroendovascular**
 233 **procedures per year per fellow; (Core)**

234

235 **I.D.4.b).(2) aneurysms; (Core)**

236

237 **I.D.4.b).(3) arteriovenous malformation; (Core)**

238

239 **I.D.4.b).(4) atherosclerotic disease of the cervical vessels; (Core)**

240

241 **I.D.4.b).(5) occlusive vascular disease and acute infarction; (Core)**

242

243 **I.D.4.b).(6) intracranial neoplasms; (Core)**

244

245 **I.D.4.b).(7) vascular anomalies of the head and neck; (Core)**

246

247 **I.D.4.b).(8) neoplasms of the head and neck; (Core)**

248

249 **I.D.4.b).(9) vascular anomalies of the spine; (Core)**

250

- 251 I.D.4.b).(10) neoplasms of the spine; and, ^(Core)
 252
 253 I.D.4.b).(11) traumatic vascular lesions of the central nervous system
 254 (CNS), head, neck, and spine. ^(Core)
 255
 256 I.D.4.c) ~~The total number of fellows in the program must be~~
 257 ~~commensurate with the capacity of the program to offer an~~
 258 ~~adequate educational experience in endovascular surgical~~
 259 ~~neuroradiology therapy.~~ ^(Detail)
 260
 261 I.E. ***A fellowship program usually occurs in the context of many learners and***
 262 ***other care providers and limited clinical resources. It should be structured***
 263 ***to optimize education for all learners present.***
 264
 265 I.E.1. **Fellows should contribute to the education of residents in core**
 266 **programs, if present.** ^(Core)
 267
 268

Subspecialty-Specific Background and Intent: It is desirable that fellows participate in the clinical teaching of child neurology, neurological surgery, and neurology residents, radiology and vascular neurology fellows, and medical students.

- 269
 270 I.E.1.a) ~~It is desirable that they participate in the clinical teaching of~~
 271 ~~neurological surgery, and of radiology fellows and medical~~
 272 ~~students.~~ ^(Detail)
 273
 274 I.E.1.b) The program in neuroendovascular intervention ~~endovascular~~
 275 ~~surgical neuroradiology~~ must not have an adverse impact on the
 276 educational experience of child neurology, diagnostic radiology,
 277 interventional radiology, neurocritical care, neuroradiology,
 278 neurological surgery, or neurology, neuroradiology, or vascular
 279 neurology residents and fellows in the same institution. ^(CoreDetail)
 280

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.

- 281
 282 II. **Personnel**
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 284 II.A. **Program Director**
 285
 286 II.A.1. **There must be one faculty member appointed as program director**
 287 **with authority and accountability for the overall program, including**
 288 **compliance with all applicable program requirements.** ^(Core)
 289

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

293
294 II.A.1.b) Final approval of the program director resides with the
295 Review Committee. ^(Core)
296

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

297
298 II.A.2. The program director and, as applicable, the program’s leadership
299 team, must be provided with support adequate for administration of
300 the program based upon its size and configuration. ^(Core)
301

302 II.A.2.a) At a minimum, the program director must be provided with the
303 dedicated time and support specified below for administration of
304 the program: ^(Core)
305

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

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

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

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

Program directors and, as applicable, members of the program leadership team, who are new to the role may need to devote additional time to program oversight and management initially as they learn and become proficient in administering the

program. It is suggested that during this initial period the support described above be increased as needed.

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

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

II.A.3.a).(1) This must include special expertise in neuroendovascular interventions, ~~endovascular surgical neuroradiology techniques;~~ (Core)

~~II.A.3.a).(1).(a) The program director must concentrate at least 50% of his or her practice in endovascular surgical neuroradiology therapy. (Core)~~

II.A.3.b) have current certification in the specialty by the American Board of Neurological Surgery, Psychiatry and Neurology, Radiology, or the American Osteopathic Board of Neurological Surgery, Neurology and Psychiatry, or Radiology, or possess qualifications judged acceptable to the Review Committee; (Core)

[Note that while the Common Program Requirements deem certification by a member board of the American Board of Medical Specialties (ABMS) or a certifying board of the American Osteopathic Association (AOA) acceptable, there is no ABMS or AOA board that offers certification in this subspecialty]

~~II.A.3.c) must include appointment by and responsibility to the program director of the core program; and, (Core)~~

II.A.3.d) must include appointment to the faculty teaching staff in the departments of neurological surgery, radiology, ~~neurological surgery~~, and child neurology, or neurology.; and, (Core)

II.A.3.e) must devote at least 50 percent of their practice to neuroendovascular intervention. (Core)

II.A.4. Program Director Responsibilities

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

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

II.A.4.a).(1) be a role model of professionalism; (Core)

Background and Intent: The program director, as the leader of the program, must serve as a role model to fellows in addition to fulfilling the technical aspects of the role. As fellows are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

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

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

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

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

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- II.A.4.a).(4)** develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the fellowship program education and at least annually thereafter, as outlined in V.B.; ^(Core)
- II.A.4.a).(5)** have the authority to approve program faculty members for participation in the fellowship program education at all sites; ^(Core)
- II.A.4.a).(6)** have the authority to remove program faculty members from participation in the fellowship program education at all sites; ^(Core)
- II.A.4.a).(7)** have the authority to remove fellows from supervising interactions and/or learning environments that do not meet the standards of the program; ^(Core)

Background and Intent: The program director has the responsibility to ensure that all who educate fellows effectively role model the Core Competencies. Working with a

fellow is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.

There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.

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- II.A.4.a).(8)** submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; ^(Core)
 - II.A.4.a).(9)** provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant subspecialty board examination(s); ^(Core)
 - II.A.4.a).(10)** provide a learning and working environment in which fellows have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; ^(Core)
 - II.A.4.a).(11)** ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; ^(Core)
 - II.A.4.a).(12)** ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a fellow; ^(Core)

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.

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- II.A.4.a).(13)** ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; ^(Core)
 - II.A.4.a).(13).(a)** Fellows must not be required to sign a non-competition guarantee or restrictive covenant. ^(Core)
 - II.A.4.a).(14)** document verification of program completion for all graduating fellows within 30 days; ^(Core)
 - II.A.4.a).(15)** provide verification of an individual fellow's completion upon the fellow's request, within 30 days; and, ^(Core)

Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of fellows who have previously completed the program. Fellows who leave the program prior to completion also require timely documentation of their summative evaluation.

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II.A.4.a).(16) obtain review and approval of the Sponsoring Institution’s DIO before submitting information or requests to the ACGME, as required in the Institutional Requirements and outlined in the ACGME Program Director’s Guide to the Common Program Requirements. ^(Core)

II.B. Faculty

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

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

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

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II.B.1. For each participating site, there must be a sufficient number of faculty members with competence to instruct and supervise all fellows at that location. ^(Core)

II.B.1.a) There must be at least one faculty member with expertise in open cerebrovascular surgery available to the program. ^(Core)

II.B.1.a).(1) This faculty member should have a teaching appointment in the departments of child neurology, neurological surgery, neurology, or radiology. ^(Detail) ~~In addition to the~~

467 program director, the physician faculty must include at
468 least one full-time member with expertise in endovascular
469 surgical neuroradiology techniques. ^(Core)

470
471 II.B.1.b) There must be at least two faculty members with expertise in
472 neuroendovascular intervention or neuroendovascular surgery for
473 each fellow in the program. ^(Core)

474
475 **II.B.2. Faculty members must:**

476
477 **II.B.2.a) be role models of professionalism;** ^(Core)

478
479 **II.B.2.b) demonstrate commitment to the delivery of safe, quality,**
480 **cost-effective, patient-centered care;** ^(Core)

481

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.

482
483 **II.B.2.c) demonstrate a strong interest in the education of fellows;** ^(Core)

484
485 **II.B.2.d) devote sufficient time to the educational program to fulfill**
486 **their supervisory and teaching responsibilities;** ^(Core)

487
488 **II.B.2.e) administer and maintain an educational environment**
489 **conducive to educating fellows;** ^(Core)

490
491 **II.B.2.f) regularly participate in organized clinical discussions,**
492 **rounds, journal clubs, and conferences;** ^(Core)

493
494 **II.B.2.g) pursue faculty development designed to enhance their skills**
495 **at least annually;** ^(Core)

496
497 **II.B.2.h) encourage and support fellows in scholarly activities; and,** ^(Core)

498
499 **II.B.2.i) provide didactic teaching and direct supervision of fellows'**
500 **performance in clinical patient management and in the procedural,**
501 **interpretive, and consultative aspects of neuroendovascular**
502 **intervention ~~endovascular surgical neuroradiology therapy.~~** ^(Core)

503

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.

504

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

- 506
507 **II.B.3.a) Faculty members must have appropriate qualifications in**
508 **their field and hold appropriate institutional appointments.**
509 **(Core)**
510
- 511 **II.B.3.b) Subspecialty physician faculty members must:**
512
- 513 **II.B.3.b).(1) have current certification in the specialty by the**
514 **American Board of Neurological Surgery, Psychiatry and**
515 **Neurology, Radiology, or the American Osteopathic**
516 **Board of Neurological Surgery, Neurology and Psychiatry,**
517 **Radiology, or possess qualifications judged acceptable**
518 **to the Review Committee;** ^(Core)
519
- 520 [Note that while the Common Program Requirements
521 deem certification by a member board of the American
522 Board of Medical Specialties (ABMS) or a certifying board
523 of the American Osteopathic Association (AOA)
524 acceptable, there is no ABMS or AOA board that offers
525 certification in this subspecialty]
526
- 527 **II.B.3.b).(2) ~~devote~~ ~~concentrate~~ at least 50 percent of their practice in**
528 **to neuroendovascular interventions ~~endovascular surgical~~**
529 **neurointerventional therapy; ^(Core)**
530
- 531 **II.B.3.b).(3) ~~The physician faculty must~~ be appointed in good standing**
532 **to the faculty staff of an institution participating in the**
533 **program; and,** ^(Core)
534
- 535 **II.B.3.b).(4) ~~The physician faculty should~~ hold primary and/or joint**
536 **appointments in the departments of child neurology or**
537 **neurology, neurological surgery, and radiology;**
538 **neurological surgery, and child neurology or neurology**
539 **departments.** ^(Detail)
540
- 541 **II.B.3.c) Any non-physician faculty members who participate in**
542 **fellowship program education must be approved by the**
543 **program director.** ^(Core)
544

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.

- 545
546 **II.B.3.d) Any other specialty physician faculty members must have**
547 **current certification in their specialty by the appropriate**
548 **American Board of Medical Specialties (ABMS) member**

549 board or American Osteopathic Association (AOA) certifying
550 board, or possess qualifications judged acceptable to the
551 Review Committee. ^(Core)

552
553 **II.B.4. Core Faculty**

554
555 **Core faculty members must have a significant role in the education**
556 **and supervision of fellows and must devote a significant portion of**
557 **their entire effort to fellow education and/or administration, and**
558 **must, as a component of their activities, teach, evaluate, and provide**
559 **formative feedback to fellows.** ^(Core)
560

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

561
562 **II.B.4.a) Core faculty members must be designated by the program**
563 **director.** ^(Core)
564

565 **II.B.4.b) Core faculty members must complete the annual ACGME**
566 **Faculty Survey.** ^(Core)
567

568 **II.B.4.c)** There must be at least two core faculty members, including the
569 program director, with expertise in neuroendovascular intervention
570 or neuroendovascular surgery. The faculty-to-fellow ratio must be
571 at least one faculty person for every fellow enrolled in the
572 program. ^(Core)
573

574 **II.C. Program Coordinator**

575
576 **II.C.1. There must be a program coordinator.** ^(Core)
577

578 **II.C.2. The program coordinator must be provided with dedicated time**
579 **and support adequate for administration of the program based**
580 **upon its size and configuration.** ^(Core)
581

582 **II.C.2.a)** At a minimum, the program coordinator must be provided with the
583 dedicated time and support specified below for administration of
584 the program:

585

<u>Number of Approved Fellow Positions</u>	<u>Minimum Support Required (FTE)</u>
<u>1-3</u>	<u>0.3</u>
<u>4-7</u>	<u>0.4</u>
<u>8 or more</u>	<u>0.5</u>

586

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

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

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

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

587

588

II.D. Other Program Personnel

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590

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

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Background and Intent: Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.

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595

II.D.1. There should be nurses and technicians skilled in neuroendovascular intervention, radiological equipment, critical care instrumentation, respiratory function, and laboratory medicine available to the program.
(Core)

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III. Fellow Appointments

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III.A. Eligibility Criteria

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III.A.1. Eligibility Requirements – Fellowship Programs

~~Neurology or Radiology: 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)~~

~~Neurological Surgery: All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program or an AOA-approved residency program. ^(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).

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III.A.1.a)

~~Neurology or Radiology: 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)~~

~~Neurological Surgery: Fellowship programs must receive verification of each entering fellow’s level of competence in the required field, upon matriculation, using ACGME Milestones evaluations from the core residency program. ^(Core)~~

III.A.1.b)

~~The preliminary year in neuroradiology may be performed in the same institution as the endovascular surgical neuroradiology fellowship or in another institution with ACGME-accredited residencies in radiology, neuroradiology, neurological surgery, and neurology. For fellows who obtain preparatory training in another institution, documentation of completion of training must be provided by the neuroradiology program director for that institution. The endovascular surgical neuroradiology program director has the responsibility and authority to assess the adequacy of the preparatory training and to verify that all preliminary training requirements have been fulfilled. ^(Detail)~~

Prerequisite Post-Graduate Education

III.A.1.b).(1)

Radiology Pathway 1: Fellows entering from diagnostic radiology must should have:

644
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- 650 III.A.1.b).(1).(a) completed an ACGME-, AOA-, or ACGME-I-
651 accredited residency in diagnostic radiology or an
652 RCPSC-accredited residency in diagnostic
653 radiology located in Canada; and, ^(Core)
654
- 655 III.A.1.b).(1).(b) completed an ACGME-, AOA-, or ACGME-I-
656 accredited fellowship (~~subspecialty residency~~) in
657 neuroradiology or an RCPSC-accredited fellowship
658 in neuroradiology located in Canada; or, ^(Core)
659
- 660 III.A.1.b).(2) Radiology Pathway 2: Fellows entering from diagnostic
661 radiology programs are eligible to be considered for
662 advanced placement in the second year of the
663 neuroendovascular intervention program, and:
664
- 665 III.A.1.b).(2).(a) must have completed an ACGME-, AOA-, or
666 ACGME-I-accredited residency in diagnostic
667 radiology or an RCPSC-accredited residency in
668 diagnostic radiology located in Canada; and, ^(Core)
669
- 670 III.A.1.b).(2).(b) must have completed an ACGME-, AOA-, or
671 ACGME-I-accredited fellowship in neuroradiology
672 or an RCPSC-accredited fellowship in
673 neuroradiology located in Canada; and, ^(Core)
674
- 675 III.A.1.b).(2).(c) during the PGY-5 of diagnostic radiology residency
676 and the PGY-6 of neuroradiology fellowship, must
677 complete six months of clinical rotations and
678 training in neurological surgery, vascular neurology,
679 or neurointensive care with emphasis on becoming
680 competent in the outpatient evaluation and care of
681 pre- and post-procedure endovascular patients, as
682 well as in the management of patients in the
683 neurointensive care environment; and, ^(Core)
684
- 685 III.A.1.b).(2).(d) during the PGY-5 of diagnostic radiology residency
686 and the PGY-6 of neuroradiology fellowship, must
687 complete at least 200 neuroangiograms under the
688 supervision of a qualified physician (an
689 ABR/AOBR-certified radiologist or interventional
690 neuroradiologist, an ABNS/AOBS-certified
691 endovascular neurosurgeon, or an ABNP/AOBNP-
692 certified interventional neurologist with appropriate
693 training). ^(Core)
694
- 695 III.A.1.b).(3) Radiology Pathway 3: Fellows entering from interventional
696 radiology must have:
697
- 698 III.A.1.b).(3).(a) completed an ACGME-, AOA-, or ACGME-I-
699 accredited residency in interventional radiology or

700		<u>an RCPSC-accredited residency in interventional radiology located in Canada.; and, ^(Core)</u>
701		
702		
703	III.A.1.b).(3).(b)	<u>completed an ACGME-, AOA-, or ACGME-I-accredited fellowship in neuroradiology or an RCPSC-accredited fellowship in neuroradiology located in Canada. ^(Core)</u>
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708	III.A.1.b).(4)	<u>Radiology Pathway 4: Fellows entering from interventional radiology are eligible to be considered for advanced placement in the second year of the neuroendovascular intervention program, and:</u>
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713	III.A.1.b).(4).(a)	<u>must have completed an ACGME-, AOA-, or ACGME-I-accredited residency in interventional radiology or an RCPSC-accredited residency in interventional radiology located in Canada; and, ^(Core)</u>
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719	III.A.1.b).(4).(b)	<u>must have completed an ACGME-, AOA-, or ACGME-I-accredited fellowship in neuroradiology or an RCPSC-accredited fellowship in neuroradiology located in Canada; and, ^(Core)</u>
720		
721		
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723		
724	III.A.1.b).(4).(c)	<u>during the PGY-5 and -6 of interventional radiology residency and the PGY-7 of neuroradiology fellowship, must complete six months of clinical rotations and training in neurological surgery, vascular neurology, or neurointensive care with emphasis on becoming competent in the outpatient evaluation and care of pre- and post-procedure endovascular patients, as well as in the management of patients in the neurointensive care environment; and, ^(Core)</u>
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735	III.A.1.b).(4).(d)	<u>during the PGY-5 and -6 of interventional radiology residency and the PGY-7 of neuroradiology fellowship, must complete at least 200 neuroangiograms under the supervision of a qualified physician (an ABR/AOBR-certified radiologist or interventional neuroradiologist, an ABNS/AOBS-certified endovascular neurosurgeon, or an ABNP/AOBNP-certified interventional neurologist with appropriate training). ^(Core)</u>
736		
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744		
745	III.A.1.b).(4).(d).(i)	<u>performed and interpreted a minimum of 100 diagnostic neuroangiograms under the supervision of a qualified physician (a board-certified radiologist, interventional neuroradiologist, endovascular</u>
746		
747		
748		
749		

750		neurosurgeon or interventional neurologist
751		with appropriate training); and, ^(Core)
752		
753	III.A.1.b).(4).(d).(ii)	completed six months' training in neurologic
754		surgery, vascular neurology, and
755		neurointensive care, during which the fellow
756		will become proficient in the outpatient
757		evaluation and care of pre and post-
758		procedure endovascular patients, as well as
759		in the management of patients in the
760		neurointensive care environment. ^(Core)
761		
762	III.A.1.b).(4).(d).(ii).(a)	This may be completed during the
763		radiology residency. ^(Detail)
764		
765	III.A.1.b).(5)	Fellows entering from neurological surgery <u>are eligible to</u>
766		<u>be considered for advanced placement in the second year</u>
767		<u>of the neuroendovascular intervention fellowship, and must</u>
768		<u>should have:</u>
769		
770	III.A.1.b).(5).(a)	completed an ACGME- or AOA-accredited
771		residency in neurological surgery, and, ^(Core)
772		
773	III.A.1.b).(5).(b)	completed a preparatory year of neuroradiology
774		training which that provides education and clinical
775		experience. The preparatory year may occur
776		during the neurological surgery residency, and
777		should include: ^(Core)
778		
779	III.A.1.b).(5).(b).(i)	a course in basic radiographic skills,
780		including radiation physics, radiation
781		biology, and radiation protection; and the
782		pharmacology of radiographic contrast
783		materials acceptable to the program director
784		where the neuroradiology training will occur;
785		^(Core)
786		
787	III.A.1.b).(5).(b).(ii)	performing and interpreting a minimum of
788		100-200 diagnostic neuroangiograms under
789		the supervision of a qualified physician (<u>an</u>
790		<u>ABR/AOBR-certified radiologist or</u>
791		<u>interventional neuroradiologist, an</u>
792		<u>ABNS/AOBS-certified endovascular</u>
793		<u>neurosurgeon, or an ABNP/AOBNP-certified</u>
794		<u>interventional neurologist with appropriate</u>
795		<u>training (a Board-certified radiologist,</u>
796		<u>interventional neuroradiologist,</u>
797		<u>endovascular neurosurgeon, or</u>
798		<u>interventional neurologist with appropriate</u>
799		<u>training); ^(Core)</u>
800		

801 III.A.1.b).(5).(b).(iii) the use of needles, catheters, guidewires,
802 and angiographic devices and materials;
803 (Core)
804
805 III.A.1.b).(5).(b).(iv) recognition and management of
806 complication of angiographic procedures;
807 and, (Core)
808
809 III.A.1.b).(5).(b).(v) understanding the fundamentals of non-
810 invasive neurovascular imaging studies
811 pertinent to the practice of
812 neuroendovascular intervention
813 ~~endovascular surgical neuroradiology,~~
814 including CT/CTA, MR/MRA, and
815 sonography of neurovascular diseases. (Core)
816

Subspecialty-Specific Background and Intent: Fellows entering from neurological surgery who have not met all of the above criteria for advanced placement may be subject to additional fellowship time up to the full 24-month curriculum at the discretion of the neuroendovascular intervention program director.

817
818 III.A.1.b).(6) Fellows entering from neurology are eligible to be
819 considered for advanced placement in the second year of
820 the neuroendovascular intervention fellowship, and must
821 should have:
822
823 III.A.1.b).(6).(a) completed an ACGME-, AOA-, or ACGME-I-
824 accredited residency in child neurology or
825 neurology or an RCPSC-accredited residency in
826 child neurology or neurology located in Canada;
827 and, (Core)
828
829 III.A.1.b).(6).(b) completed an ACGME-, AOA-, or ACGME-I-
830 accredited ~~one-year~~ vascular/~~stroke~~ neurology or
831 neurocritical care program or an RCPSC-accredited
832 one-year vascular/stroke neurology program
833 located in Canada that includes at least three
834 months of neuro-intensive care; and, (Core)
835
836 ~~III.A.1.b).(6).(c) completed three months of clinical experience~~
837 ~~within an ACGME-, AOA-, ACGME-I-accredited~~
838 ~~neurological surgery program or an RCPSC-~~
839 ~~accredited neurological surgery program located in~~
840 ~~Canada;~~ (Core)
841
842 III.A.1.b).(6).(d) completed a preparatory year of neuroradiology
843 training, ~~which~~ that provides education and clinical
844 experience that includes: (Core)
845
846 III.A.1.b).(6).(d).(i) a course in basic radiographic skills,
847 including radiation physics, radiation

848		biology, and radiation protection; and the
849		pharmacology of radiographic contrast
850		materials acceptable to the program director
851		where the neuroradiology training will occur;
852		(Core)
853		
854	III.A.1.b).(6).(d).(ii)	performing and interpreting a minimum of
855		400-200 diagnostic neuroangiograms under
856		the supervision of a qualified physician (<u>an</u>
857		<u>ABR/AOBR-certified radiologist or</u>
858		<u>interventional neuroradiologist, an</u>
859		<u>ABNS/AOBS-certified endovascular</u>
860		<u>neurosurgeon, or an ABNP/AOBNP-certified</u>
861		<u>interventional neurologist with appropriate</u>
862		<u>training</u>) (Board-certified neuroradiologist,
863		interventional neuroradiologist,
864		endovascular neurosurgeon, or intervening
865		neurologist with appropriate training); (Core)
866		
867	III.A.1.b).(6).(d).(iii)	instruction in the use of needles, catheters,
868		guidewires, and angiographic devices and
869		materials; (Core)
870		
871	III.A.1.b).(6).(d).(iv)	recognition and management of
872		complication of angiographic procedures;
873		and, (Core)
874		
875	III.A.1.b).(6).(d).(v)	understanding the fundamentals of non-
876		invasive neurovascular imaging studies
877		pertinent to the practice of
878		<u>neuroendovascular intervention</u>
879		endovascular surgical neuroradiology,
880		including CT/CTA, MR/MRA and
881		sonography of neurovascular diseases. (Core)
882		

<p><u>Subspecialty-Specific Background and Intent: Fellows entering from neurology who have not met all of the above criteria for advanced placement may be subject to additional fellowship time up to the full 24-month curriculum at the discretion of the neuroendovascular intervention program director.</u></p>
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883		
884	III.A.1.c)	Fellow Eligibility Exception
885		
886		The Review Committee for Radiology will allow the following
887		exception to the fellowship eligibility requirements:
888		
889	III.A.1.c).(1)	An ACGME-accredited fellowship program may accept
890		an exceptionally qualified international graduate
891		applicant who does not satisfy the eligibility
892		requirements listed in III.A.1., but who does meet all of
893		the following additional qualifications and conditions:
894		(Core)

- 895
896 ~~III.A.1.c).(1).(a) ————— evaluation by the program director and~~
897 ~~fellowship selection committee of the~~
898 ~~applicant's suitability to enter the program,~~
899 ~~based on prior training and review of the~~
900 ~~summative evaluations of training in the core~~
901 ~~specialty; and, ^(Core)~~
902
903 ~~III.A.1.c).(1).(b) ————— review and approval of the applicant's~~
904 ~~exceptional qualifications by the GMEC; and,~~
905 ~~^(Core)~~
906
907 ~~III.A.1.c).(1).(c) ————— verification of Educational Commission for~~
908 ~~Foreign Medical Graduates (ECFMG)~~
909 ~~certification. ^(Core)~~
910
911 ~~III.A.1.c).(2) ————— Applicants accepted through this exception must have~~
912 ~~an evaluation of their performance by the Clinical~~
913 ~~Competency Committee within 12 weeks of~~
914 ~~matriculation. ^(Core)~~
915

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

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

- 916
917 **III.B. The program director must not appoint more fellows than approved by the**
918 **Review Committee. ^(Core)**
919
920 **III.B.1. All complement increases must be approved by the Review**
921 **Committee. ^(Core)**
922
923 **III.C. Fellow Transfers**
924
925 **The program must obtain verification of previous educational experiences**
926 **and a summative competency-based performance evaluation prior to**
927 **acceptance of a transferring fellow, and Milestones evaluations upon**
928 **matriculation. ^(Core)**
929

930 IV. Educational Program

931

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

935

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

938

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

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

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

955

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

958

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

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

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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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970 IV.A.4. structured educational activities beyond direct patient care; and,
971 (Core)

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Background and Intent: Patient care-related educational activities, such as morbidity and mortality conferences, tumor boards, surgical planning conferences, case

discussions, etc., allow fellows to gain medical knowledge directly applicable to the patients they serve. Programs should define those educational activities in which fellows are expected to participate and for which time is protected. Further specification can be found in IV.C.

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

IV.B. ACGME Competencies

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

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

IV.B.1.a) Professionalism

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

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

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

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

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

IV.B.1.b).(1).(a) Fellows must demonstrate competence as consultants under the supervision of neuroendovascular intervention ~~endovascular surgical neuroradiology~~ practitioners. (Core)

1001	IV.B.1.b).(1).(b)	<u>Fellows must demonstrate competence in:</u>
1002		
1003	IV.B.1.b).(1).(b).(i)	<u>recognizing the signs and symptoms of disorders amenable to diagnosis and treatment by neuroendovascular intervention techniques;</u> (Core)
1004		
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1007		
1008	IV.B.1.b).(1).(b).(ii)	<u>the recognition and management of indications and contraindications to neuroendovascular intervention procedures;</u> (Core)
1009		
1010		
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1012		
1013	IV.B.1.b).(1).(b).(iii)	<u>managing the pre- and post-operative care of endovascular patients; and,</u> (Core)
1014		
1015		
1016	IV.B.1.b).(1).(b).(iv)	<u>managing patients requiring neurointensive care.</u> (Core)
1017		
1018		
1019	IV.B.1.b).(2)	Fellows must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)
1020		
1021		
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1023	IV.B.1.b).(2).(a)	Fellows must participate in and demonstrate competence in:
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1025		
1026	IV.B.1.b).(2).(a).(i)	personally performing and analyzing a broad spectrum of endovascular procedures;
1027		
1028		
1029		
1030	IV.B.1.b).(2).(a).(i).(a)	Fellows must perform a minimum of 100 therapeutic endovascular procedures; (Core)
1031		
1032		
1033		
1034	IV.B.1.b).(2).(a).(ii)	the management of patients with neurological disease, the performance of <u>neuroendovascular intervention endovascular surgical neuroradiology</u> procedures, and the integration of <u>neuroendovascular intervention endovascular surgical neuroradiology</u> therapy into the clinical management of patients;
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1044	IV.B.1.b).(2).(a).(iii)	performing clinical pre-procedure evaluations of patients and their preliminary diagnostic studies, and consulting with clinicians on other services;
1045		
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1047		
1048		
1049	IV.B.1.b).(2).(a).(iv)	performing diagnostic and therapeutic <u>neuroendovascular intervention</u>
1050		

1051		endovascular surgical neuroradiology
1052		procedures; (Core)
1053		
1054	IV.B.1.b).(2).(a).(v)	<u>performing physical examinations to</u>
1055		<u>evaluate patients with neurological</u>
1056		<u>disorders;</u> (Core)
1057		
1058	IV.B.1.b).(2).(a).(vi)	<u>performing neurological examinations to</u>
1059		<u>evaluate patients with neurological</u>
1060		<u>disorders;</u> (Core)
1061		
1062	IV.B.1.b).(2).(a).(vii)	generating procedural reports; and, (Core)
1063		
1064	IV.B.1.b).(2).(a).(viii)	providing short-term and long-term post-
1065		procedure follow-up care, including
1066		neurointensive care. (Core)
1067		
1068	IV.B.1.b).(2).(a).(viii).(a)	The continuity of care must be of
1069		sufficient duration to ensure that the
1070		fellow is familiar with the outcome of
1071		all <u>neuroendovascular intervention</u>
1072		endovascular surgical
1073		neuroradiology procedures. (Core)
1074		
1075	IV.B.1.c)	Medical Knowledge
1076		
1077		Fellows must demonstrate knowledge of established and
1078		evolving biomedical, clinical, epidemiological and social-
1079		behavioral sciences, as well as the application of this
1080		knowledge to patient care. (Core)
1081		
1082	IV.B.1.c).(1)	<u>Fellows must demonstrate knowledge of the:</u>
1083		
1084	IV.B.1.c).(1).(a)	<u>clinical and technical aspects of neuroendovascular</u>
1085		<u>intervention procedures;</u> (Core)
1086		
1087	IV.B.1.c).(1).(b)	<u>fundamentals of imaging physics and radiation</u>
1088		<u>biology;</u> (Core)
1089		
1090	IV.B.1.c).(1).(c)	<u>interpretation of neuroangiographic studies</u>
1091		<u>pertinent to the practice;</u> (Core)
1092		
1093	IV.B.1.c).(1).(d)	<u>medical and surgical alternatives to</u>
1094		<u>neuroendovascular intervention procedures; and,</u>
1095		(Core)
1096		
1097	IV.B.1.c).(1).(e)	<u>pathophysiology and natural history of neurological</u>
1098		<u>disorders.</u> (Core)
1099		
1100	IV.B.1.c).(2)	Fellows must demonstrate competence in their knowledge
1101		of the following didactic component areas:

1102		
1103	IV.B.1.c).(2).(a)	anatomical and physiologic basic knowledge, including: ^(Core)
1104		
1105		
1106	IV.B.1.c).(2).(a).(i)	arterial and venous angiographic anatomy of the brain, spine, spinal cord, and head and neck, to include: ^(Core)
1107		
1108		
1109		
1110	IV.B.1.c).(2).(a).(i).(a)	autoregulation; ^(Core)
1111		
1112	IV.B.1.c).(2).(a).(i).(b)	cerebral blood flow; ^(Core)
1113		
1114	IV.B.1.c).(2).(a).(i).(c)	collateral circulation; ^(Core)
1115		
1116	IV.B.1.c).(2).(a).(i).(d)	dangerous anastomosis; ^(Core)
1117		
1118	IV.B.1.c).(2).(a).(i).(e)	variants of anatomy; and, ^(Core)
1119		
1120	IV.B.1.c).(2).(a).(i).(f)	vascular distributions and supply/drainage. ^(Core)
1121		
1122		
1123	IV.B.1.c).(2).(a).(ii)	related bony and soft tissue anatomy and physiology, to include: ^(Core)
1124		
1125		
1126	IV.B.1.c).(2).(a).(ii).(a)	brain, neck, face, and spine soft tissue anatomy and physiology; ^(Core)
1127		
1128		
1129	IV.B.1.c).(2).(a).(ii).(b)	ligamentous, articular and muscular anatomy; and, ^(Core)
1130		
1131		
1132	IV.B.1.c).(2).(a).(ii).(c)	vertebral, face, and skull bony anatomy; ^(Core)
1133		
1134		
1135	IV.B.1.c).(2).(b)	pharmacology of the CNS and vasculature and relevant brain physiology, including: ^(Core)
1136		
1137		
1138	IV.B.1.c).(2).(b).(i)	agents used in provocative testing; ^(Core)
1139		
1140	IV.B.1.c).(2).(b).(ii)	coagulation cascade; ^(Core)
1141		
1142	IV.B.1.c).(2).(b).(ii).(a)	antiaggregants; ^(Core)
1143		
1144	IV.B.1.c).(2).(b).(ii).(b)	anticoagulants; and, ^(Core)
1145		
1146	IV.B.1.c).(2).(b).(ii).(c)	thrombolytics. ^(Core)
1147		
1148	IV.B.1.c).(2).(b).(iii)	contrast agents; ^(Core)
1149		
1150	IV.B.1.c).(2).(b).(iv)	vasodilators and constrictors; ^(Core)
1151		

1152	IV.B.1.c).(2).(c)	embolic, sclerosing, ablative, and bone stabilization
1153		agents, including; ^(Core)
1154		
1155	IV.B.1.c).(2).(c).(i)	allergic reaction control; ^(Core)
1156		
1157	IV.B.1.c).(2).(c).(ii)	blood pressure control; ^(Core)
1158		
1159	IV.B.1.c).(2).(c).(iii)	heart rate control; ^(Core)
1160		
1161	IV.B.1.c).(2).(c).(iv)	infection; and, ^(Core)
1162		
1163	IV.B.1.c).(2).(c).(v)	stroke risk reduction. ^(Core)
1164		
1165	IV.B.1.c).(2).(d)	technical aspects of <u>neuroendovascular</u>
1166		<u>intervention</u> -endovascular surgical neuroradiology,
1167		including; ^(Core)
1168		
1169	IV.B.1.c).(2).(d).(i)	catheter and delivery systems; ^(Core)
1170		
1171	IV.B.1.c).(2).(d).(ii)	collateral network manipulations and flow
1172		diversion; ^(Core)
1173		
1174	IV.B.1.c).(2).(d).(iii)	complications of angiography and
1175		embolization; ^(Core)
1176		
1177	IV.B.1.c).(2).(d).(iv)	direct access/therapeutic injection
1178		techniques, to include biopsy and
1179		aspiration; ^(Core)
1180		
1181	IV.B.1.c).(2).(d).(v)	electrophysiology; ^(Core)
1182		
1183	IV.B.1.c).(2).(d).(vi)	embolic, sclerosing, and stabilizing agents
1184		in cerebral, spinal, and head and neck
1185		embolization; ^(Core)
1186		
1187	IV.B.1.c).(2).(d).(vii)	flow-controlled navigations and
1188		embolization; ^(Core)
1189		
1190	IV.B.1.c).(2).(d).(viii)	imaging of the vascular system; ^(Core)
1191		
1192	IV.B.1.c).(2).(d).(ix)	provocative testing; and, ^(Core)
1193		
1194	IV.B.1.c).(2).(d).(x)	stents, balloons, and revascularization
1195		devices. ^(Core)
1196		
1197	IV.B.1.c).(3)	Fellows must demonstrate knowledge of the classification,
1198		clinical presentation, imaging appearance, natural history,
1199		epidemiology, hemodynamic and physiologic basis for
1200		disease and treatment, indications and techniques for
1201		treatment, contraindications for treatment, treatment
1202		alternatives, combined therapies, risks of treatment, and

- 1203 complication management for all the disease states listed
- 1204 below: ^(Core)
- 1205
- 1206 IV.B.1.c).(3).(a) arteriopathies; ^(Core)
- 1207
- 1208 IV.B.1.c).(3).(b) arteriovenous malformations and fistulae; ^(Core)
- 1209
- 1210 IV.B.1.c).(3).(c) hemorrhage and epistaxis; ^(Core)
- 1211
- 1212 IV.B.1.c).(3).(d) other vascular malformations and lesions; ^(Core)
- 1213
- 1214 IV.B.1.c).(3).(e) stroke and cerebral ischemia; ^(Core)
- 1215
- 1216 IV.B.1.c).(3).(f) tumors; ^(Core)
- 1217
- 1218 IV.B.1.c).(3).(g) vascular trauma; and, ^(Core)
- 1219
- 1220 IV.B.1.c).(3).(h) vertebral fracture and degeneration. ^(Core)

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1222 **IV.B.1.d) Practice-based Learning and Improvement**

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1224 **Fellows must demonstrate the ability to investigate and**

1225 **evaluate their care of patients, to appraise and assimilate**

1226 **scientific evidence, and to continuously improve patient care**

1227 **based on constant self-evaluation and lifelong learning. ^(Core)**

1228

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.

1229

1230 **IV.B.1.e) Interpersonal and Communication Skills**

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1232 **Fellows must demonstrate interpersonal and communication**

1233 **skills that result in the effective exchange of information and**

1234 **collaboration with patients, their families, and health**

1235 **professionals. ^(Core)**

1236

1237 **IV.B.1.f) Systems-based Practice**

1238

1239 **Fellows must demonstrate an awareness of and**

1240 **responsiveness to the larger context and system of health**

1241 **care, including the social determinants of health, as well as**

1242 **the ability to call effectively on other resources to provide**

1243 **optimal health care. ^(Core)**

1244

1245 **IV.C. Curriculum Organization and Fellow Experiences**

1246		
1247	IV.C.1.	The curriculum must be structured to optimize fellow educational experiences, the length of these experiences, and supervisory continuity. ^(Core)
1248		
1249		
1250		
1251	IV.C.1.a)	The assignment of educational experiences should be structured to minimize the frequency of transitions. ^(Detail)
1252		
1253		
1254	IV.C.1.b)	Educational experiences should be of sufficient length to provide a quality educational experience defined by ongoing supervision, longitudinal relationships with faculty members, and high-quality assessment and feedback. ^(Detail)
1255		
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1259	IV.C.2.	The program must provide instruction and experience in pain management if applicable for the subspecialty, including recognition of the signs of addiction. ^(Core)
1260		
1261		
1262		
1263	IV.C.3.	The curriculum: <u>must include:</u>
1264		
1265	IV.C.3.a)	<u>must include</u> 24 continuous months of neuroendovascular intervention clinical training 12 continuous months in endovascular surgical neuroradiology under close supervision; ^(Core)
1266		
1267		
1268		
1269	IV.C.3.b)	<u>must include</u> didactic and clinical experiences that encompass the full clinical spectrum of neuroendovascular intervention therapy; ^(Core)
1270		
1271		
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1273	<u>IV.C.3.c)</u>	<u>should include procedural education using simulation;</u> ^(Detail)
1274		
1275	IV.C.3.d)	<u>should include</u> education and experience in invasive functional testing; and, ^(Detail)
1276		
1277		
1278	IV.C.3.e)	<u>must include</u> education and training in <u>neuroendovascular intervention</u> endovascular surgical neuroradiology in an environment conducive to investigative studies of a clinical or basic science nature. ^(Core)
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1283	IV.C.4.	Didactics
1284		
1285	IV.C.4.a)	Formal teaching conferences specifically developed for the fellows must be provided. ^(Core)
1286		
1287		
1288	IV.C.4.a).(1)	Teaching conferences must be organized by the program faculty members and held at least once a week. ^(Core)
1289		
1290		
1291	IV.C.4.a).(2)	Conferences must include journal clubs, pathology meetings, and neuroanatomy dissection, simulation, and flow-model courses; ^(Core)
1292		
1293		
1294		
1295	IV.C.4.a).(3)	Journal club must be held on a quarterly basis. ^(Core)
1296		

- 1297 IV.C.4.a).(4) Morbidity and mortality review conferences related to the
 1298 performance of neuroendovascular intervention
 1299 procedures must be held at least monthly. (Core)
 1300
 1301 IV.C.4.a).(4).(a) These reviews should be interdisciplinary and
 1302 include joint conferences with neurology,
 1303 neurological surgery, and radiology. (Core)
 1304
 1305 IV.C.4.a).(4).(b) Fellows must actively participate in these reviews.
 1306 (Core)
 1307
 1308 IV.C.4.a).(5) Teaching conferences must cover the full extent of
 1309 neuroendovascular intervention, including the use of
 1310 minimally invasive catheter-based technology, radiologic
 1311 imaging, and clinical expertise to diagnose and treat
 1312 diseases of the CNS, head, neck, and spine. (Core)
 1313
 1314 IV.C.4.a).(6) Conference formats should allow for interactive discussion
 1315 of the selected topics. (Detail)
 1316
 1317 IV.C.4.b) Fellows must attend and participate in conferences. (Core)
 1318
 1319 IV.C.4.b).(1) Protected didactic and interactive conference time must be
 1320 provided, including for interdepartmental meetings with
 1321 neurosurgeons, neuroradiologists, and neurologists. (Core)
 1322
 1323 IV.C.4.b).(2) Each fellow should attend and actively participate in
 1324 interdepartmental meetings and conferences with child
 1325 neurology or neurology, neurological surgery,
 1326 neuropathology, and neuroradiology. (Detail)
 1327

Subspecialty-Specific Background and Intent: The Review Committee values the contributions of extramural education towards enhancing the fellows' overall educational experience. Fellow attendance and participation in local extramural conferences, national meetings, or post-graduate coursework in neuroendovascular intervention therapy during the program is encouraged.

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 1329 IV.C.5. Fellow Experiences
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 1331 IV.C.5.a) Each fellow must complete a minimum of 250 interventional
 1332 procedures, which must include: (Core)
 1333
 1334 IV.C.5.a).(1) 40 aneurysm treatments, including 10 ruptured aneurysms;
 1335 (Core)
 1336
 1337 IV.C.5.a).(2) 20 intracranial embolizations (AVM, AVF, tumor); (Core)
 1338
 1339 IV.C.5.a).(3) 20 intracranial or extracranial stent placements (at least
 1340 five in each category); (Core)
 1341
 1342 IV.C.5.a).(4) 40 acute ischemic stroke treatments; (Core)

1343		
1344	IV.C.5.a).(5)	<u>15 head and neck embolizations; and,</u> (Core)
1345		
1346	IV.C.5.a).(6)	<u>five spinal angiograms and/or embolizations.</u> (Core)
1347		
1348	IV.C.5.b)	<u>Each fellow must maintain a personal case log of their clinical experiences, which must be verified by the program director at the completion of the program.</u> (Core)
1349		
1350		
1351		
1352	IV.C.5.c)	Fellows must participate in daily rounds with the <u>neuroendovascular intervention</u> endovascular surgical neuroradiology faculty members during which patient management decisions are discussed and made. (Core)
1353		
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1356		
1357	IV.C.5.d)	Direct supervision of fellow interactions with patients must be ensured so that appropriate standards of care and concern for patient welfare are strictly maintained. (Core)
1358		
1359		
1360		
1361	IV.C.5.d).(1)	Fellow communication, consultation, and coordination of care with the referring clinical staff members and clinical services must be maintained and documented with appropriate notes in the medical record. (Detail)
1362		
1363		
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1366	IV.D.	Scholarship
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1368		<i>Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through fellow participation in scholarly activities as defined in the subspecialty-specific Program Requirements. Scholarly activities may include discovery, integration, application, and teaching.</i>
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1377		<i>The ACGME recognizes the diversity of fellowships and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. 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.</i>
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1386	IV.D.1.	Program Responsibilities
1387		
1388	IV.D.1.a)	The program must demonstrate evidence of scholarly activities, consistent with its mission(s) and aims. (Core)
1389		
1390		
1391	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)
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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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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)‡

IV.D.2.b).(2) peer-reviewed publication. (Outcome)

IV.D.3. Fellow Scholarly Activity

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1431

- 1432 IV.D.3.a) The curriculum must advance fellows' knowledge of the basic
 1433 principles of research, including how research is conducted,
 1434 evaluated, explained to patients, and applied to patient care. (Core)
 1435
 1436 IV.D.3.b) Fellows should participate in scholarly activity. (Detail)
 1437
 1438 IV.D.3.c) Fellows should participate in research activities with residents and
 1439 staff members in other related specialties. (Detail)
 1440
 1441 **V. Evaluation**
 1442
 1443 **V.A. Fellow Evaluation**
 1444
 1445 **V.A.1. Feedback and Evaluation**
 1446

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower fellows to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring fellow learning* and providing ongoing feedback that can be used by fellows to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

- fellows identify their strengths and weaknesses and target areas that need work
- program directors and faculty members recognize where fellows are struggling and address problems immediately

Summative evaluation is *evaluating a fellow's learning* by comparing the fellows against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when fellows or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the fellowship program.

Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a new specialist to one with growing subspecialty expertise.

- 1447
 1448 **V.A.1.a) Faculty members must directly observe, evaluate, and**
 1449 **frequently provide feedback on fellow performance during**
 1450 **each rotation or similar educational assignment. (Core)**
 1451
 1452 V.A.1.a).(1) Assessment should include regular evaluation of fellows'
 1453 knowledge, skills, and overall performance, including the
 1454 development of professional attitudes consistent with being
 1455 a physician. (Core)

- 1456
 1457 V.A.1.a).(1).(a) The assessment must include cognitive, motor, and
 1458 interpersonal skills, as well as judgment. (Core)
 1459
 1460 V.A.1.a).(2) The program must provide the fellows with quarterly
 1461 feedback to communicate performance evaluations and
 1462 discuss their procedure logs. (Core)
 1463
 1464 V.A.1.a).(2).(a) At the completion of the educational program, the
 1465 program director must submit the entire clinical
 1466 experience of the neuroendovascular intervention
 1467 ~~endovascular surgical neuroradiology~~ program and
 1468 the fellows. (Core)
 1469

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.

- 1470
 1471 V.A.1.b) Evaluation must be documented at the completion of the
 1472 assignment. (Core)
 1473
 1474 V.A.1.b).(1) For block rotations of greater than three months in
 1475 duration, evaluation must be documented at least
 1476 every three months. (Core)
 1477
 1478 V.A.1.b).(2) Longitudinal experiences such as continuity clinic in
 1479 the context of other clinical responsibilities must be
 1480 evaluated at least every three months and at
 1481 completion. (Core)
 1482
 1483 V.A.1.c) The program must provide an objective performance
 1484 evaluation based on the Competencies and the subspecialty-
 1485 specific Milestones, and must: (Core)
 1486
 1487 V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers,
 1488 patients, self, and other professional staff members);
 1489 and, (Core)
 1490
 1491 V.A.1.c).(2) provide that information to the Clinical Competency
 1492 Committee for its synthesis of progressive fellow
 1493 performance and improvement toward unsupervised
 1494 practice. (Core)
 1495

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.

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

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a fellow's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Fellows should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, fellows should develop an individualized learning plan.

Fellows who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the fellow, will take a variety of forms based on the specific learning needs of the fellow. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of fellow progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

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- 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)

1525	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)
1526		
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1531	V.A.2.a).(2)	The final evaluation must:
1532		
1533	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)
1534		
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1537		
1538	V.A.2.a).(2).(b)	verify that the fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; ^(Core)
1539		
1540		
1541		
1542	V.A.2.a).(2).(c)	consider recommendations from the Clinical Competency Committee; and, ^(Core)
1543		
1544		
1545	V.A.2.a).(2).(d)	be shared with the fellow upon completion of the program. ^(Core)
1546		
1547		
1548	V.A.3.	A Clinical Competency Committee must be appointed by the
1549		program director. ^(Core)
1550		
1551	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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1558	V.A.3.b)	The Clinical Competency Committee must:
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1560	V.A.3.b).(1)	review all fellow evaluations at least semi-annually; ^(Core)
1561		
1562		
1563	V.A.3.b).(2)	determine each fellow’s progress on achievement of the subspecialty-specific Milestones; and, ^(Core)
1564		
1565		
1566	V.A.3.b).(3)	meet prior to the fellows’ semi-annual evaluations and advise the program director regarding each fellow’s progress. ^(Core)
1567		
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1570	V.B.	Faculty Evaluation
1571		
1572	V.B.1.	The program must have a process to evaluate each faculty member’s performance as it relates to the educational program at least annually. ^(Core)
1573		
1574		
1575		

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.

- 1576
1577 **V.B.1.a)** This evaluation must include a review of the faculty member's
1578 clinical teaching abilities, engagement with the educational
1579 program, participation in faculty development related to their
1580 skills as an educator, clinical performance, professionalism,
1581 and scholarly activities. ^(Core)
1582
1583 **V.B.1.b)** This evaluation must include written, confidential evaluations
1584 by the fellows. ^(Core)
1585
1586 **V.B.2.** Faculty members must receive feedback on their evaluations at least
1587 annually. ^(Core)
1588
1589 **V.B.3.** Results of the faculty educational evaluations should be
1590 incorporated into program-wide faculty development plans. ^(Core)
1591

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.

- 1592
1593 **V.C. Program Evaluation and Improvement**
1594
1595 **V.C.1.** The program director must appoint the Program Evaluation
1596 Committee to conduct and document the Annual Program
1597 Evaluation as part of the program's continuous improvement
1598 process. ^(Core)
1599

- 1600 **V.C.1.a)** **The Program Evaluation Committee must be composed of at**
 1601 **least two program faculty members, at least one of whom is a**
 1602 **core faculty member, and at least one fellow.** ^(Core)
 1603
 1604 **V.C.1.b)** **Program Evaluation Committee responsibilities must include:**
 1605
 1606 **V.C.1.b).(1)** **acting as an advisor to the program director, through**
 1607 **program oversight;** ^(Core)
 1608
 1609 **V.C.1.b).(2)** **review of the program’s self-determined goals and**
 1610 **progress toward meeting them;** ^(Core)
 1611
 1612 **V.C.1.b).(3)** **guiding ongoing program improvement, including**
 1613 **development of new goals, based upon outcomes;**
 1614 **and,** ^(Core)
 1615
 1616 **V.C.1.b).(4)** **review of the current operating environment to identify**
 1617 **strengths, challenges, opportunities, and threats as**
 1618 **related to the program’s mission and aims.** ^(Core)
 1619

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.

- 1620
 1621 **V.C.1.c)** **The Program Evaluation Committee should consider the**
 1622 **following elements in its assessment of the program:**
 1623
 1624 **V.C.1.c).(1)** **curriculum;** ^(Core)
 1625
 1626 **V.C.1.c).(2)** **outcomes from prior Annual Program Evaluation(s);**
 1627 **(Core)**
 1628
 1629 **V.C.1.c).(3)** **ACGME letters of notification, including citations,**
 1630 **Areas for Improvement, and comments;** ^(Core)
 1631
 1632 **V.C.1.c).(4)** **quality and safety of patient care;** ^(Core)
 1633
 1634 **V.C.1.c).(5)** **aggregate fellow and faculty:**
 1635
 1636 **V.C.1.c).(5).(a)** **well-being;** ^(Core)
 1637
 1638 **V.C.1.c).(5).(b)** **recruitment and retention;** ^(Core)
 1639
 1640 **V.C.1.c).(5).(c)** **workforce diversity;** ^(Core)
 1641
 1642 **V.C.1.c).(5).(d)** **engagement in quality improvement and patient**
 1643 **safety;** ^(Core)
 1644

1645	V.C.1.c).(5).(e)	scholarly activity; ^(Core)
1646		
1647	V.C.1.c).(5).(f)	ACGME Resident/Fellow and Faculty Surveys
1648		(where applicable); and, ^(Core)
1649		
1650	V.C.1.c).(5).(g)	written evaluations of the program. ^(Core)
1651		
1652	V.C.1.c).(6)	aggregate fellow:
1653		
1654	V.C.1.c).(6).(a)	achievement of the Milestones; ^(Core)
1655		
1656	V.C.1.c).(6).(b)	in-training examinations (where applicable);
1657		^(Core)
1658		
1659	V.C.1.c).(6).(c)	board pass and certification rates; and, ^(Core)
1660		
1661	V.C.1.c).(6).(d)	graduate performance. ^(Core)
1662		
1663	V.C.1.c).(7)	aggregate faculty:
1664		
1665	V.C.1.c).(7).(a)	evaluation; and, ^(Core)
1666		
1667	V.C.1.c).(7).(b)	professional development ^(Core)
1668		
1669	V.C.1.d)	The Program Evaluation Committee must evaluate the
1670		program's mission and aims, strengths, areas for
1671		improvement, and threats. ^(Core)
1672		
1673	V.C.1.e)	The annual review, including the action plan, must:
1674		
1675	V.C.1.e).(1)	be distributed to and discussed with the members of
1676		the teaching faculty and the fellows; and, ^(Core)
1677		
1678	V.C.1.e).(2)	be submitted to the DIO. ^(Core)
1679		
1680	V.C.2.	The program must participate in a Self-Study prior to its 10-Year
1681		Accreditation Site Visit. ^(Core)
1682		
1683	V.C.2.a)	A summary of the Self-Study must be submitted to the DIO.
1684		^(Core)
1685		

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

well as information on how to prepare for the [10-Year Accreditation Site Visit](#), is available on the ACGME website.

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VI. The Learning and Working Environment

Fellowship education must occur in the context of a learning and working environment that emphasizes the following principles:

- *Excellence in the safety and quality of care rendered to patients by fellows today*
- *Excellence in the safety and quality of care rendered to patients by today's fellows in their future practice*
- *Excellence in professionalism through faculty modeling of:*
 - *the effacement of self-interest in a humanistic environment that supports the professional development of physicians*
 - *the joy of curiosity, problem-solving, intellectual rigor, and discovery*
- *Commitment to the well-being of the students, residents, fellows, faculty members, and all members of the health care team*

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

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

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VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

1711 **VI.A.1. Patient Safety and Quality Improvement**
 1712
 1713 *All physicians share responsibility for promoting patient safety and*
 1714 *enhancing quality of patient care. Graduate medical education must*
 1715 *prepare fellows to provide the highest level of clinical care with*
 1716 *continuous focus on the safety, individual needs, and humanity of*
 1717 *their patients. It is the right of each patient to be cared for by fellows*
 1718 *who are appropriately supervised; possess the requisite knowledge,*
 1719 *skills, and abilities; understand the limits of their knowledge and*
 1720 *experience; and seek assistance as required to provide optimal*
 1721 *patient care.*
 1722
 1723 *Fellows must demonstrate the ability to analyze the care they*
 1724 *provide, understand their roles within health care teams, and play an*
 1725 *active role in system improvement processes. Graduating fellows*
 1726 *will apply these skills to critique their future unsupervised practice*
 1727 *and effect quality improvement measures.*
 1728
 1729 *It is necessary for fellows and faculty members to consistently work*
 1730 *in a well-coordinated manner with other health care professionals to*
 1731 *achieve organizational patient safety goals.*
 1732

1733 **VI.A.1.a) Patient Safety**

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 1735 **VI.A.1.a).(1) Culture of Safety**

1736
 1737 *A culture of safety requires continuous identification*
 1738 *of vulnerabilities and a willingness to transparently*
 1739 *deal with them. An effective organization has formal*
 1740 *mechanisms to assess the knowledge, skills, and*
 1741 *attitudes of its personnel toward safety in order to*
 1742 *identify areas for improvement.*
 1743

1744 **VI.A.1.a).(1).(a)** The program, its faculty, residents, and fellows
 1745 must actively participate in patient safety
 1746 systems and contribute to a culture of safety.
 1747 (Core)

1748
 1749 **VI.A.1.a).(1).(b)** The program must have a structure that
 1750 promotes safe, interprofessional, team-based
 1751 care. (Core)

1752
 1753 **VI.A.1.a).(2) Education on Patient Safety**

1754
 1755 Programs must provide formal educational activities
 1756 that promote patient safety-related goals, tools, and
 1757 techniques. (Core)
 1758

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

1759

1760	VI.A.1.a).(3)	Patient Safety Events
1761		
1762		<i>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.</i>
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1772	VI.A.1.a).(3).(a)	Residents, fellows, faculty members, and other clinical staff members must:
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1774		
1775	VI.A.1.a).(3).(a).(i)	know their responsibilities in reporting patient safety events at the clinical site;
1776		<small>(Core)</small>
1777		
1778		
1779	VI.A.1.a).(3).(a).(ii)	know how to report patient safety events, including near misses, at the clinical site; and,
1780		<small>(Core)</small>
1781		
1782		
1783	VI.A.1.a).(3).(a).(iii)	be provided with summary information of their institution’s patient safety reports.
1784		<small>(Core)</small>
1785		
1786		
1787	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.
1788		<small>(Core)</small>
1789		
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1793		
1794	VI.A.1.a).(4)	Fellow Education and Experience in Disclosure of Adverse Events
1795		
1796		
1797		<i>Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for fellows to develop and apply.</i>
1798		
1799		
1800		
1801		
1802		
1803	VI.A.1.a).(4).(a)	All fellows must receive training in how to disclose adverse events to patients and families.
1804		<small>(Core)</small>
1805		
1806		
1807	VI.A.1.a).(4).(b)	Fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated.
1808		<small>(Detail)</small>
1809		
1810		

1811	VI.A.1.b)	Quality Improvement
1812		
1813	VI.A.1.b).(1)	Education in Quality Improvement
1814		
1815		<i>A cohesive model of health care includes quality-</i>
1816		<i>related goals, tools, and techniques that are necessary</i>
1817		<i>in order for health care professionals to achieve</i>
1818		<i>quality improvement goals.</i>
1819		
1820	VI.A.1.b).(1).(a)	Fellows must receive training and experience in
1821		quality improvement processes, including an
1822		understanding of health care disparities. ^(Core)
1823		
1824	VI.A.1.b).(2)	Quality Metrics
1825		
1826		<i>Access to data is essential to prioritizing activities for</i>
1827		<i>care improvement and evaluating success of</i>
1828		<i>improvement efforts.</i>
1829		
1830	VI.A.1.b).(2).(a)	Fellows and faculty members must receive data
1831		on quality metrics and benchmarks related to
1832		their patient populations. ^(Core)
1833		
1834	VI.A.1.b).(3)	Engagement in Quality Improvement Activities
1835		
1836		<i>Experiential learning is essential to developing the</i>
1837		<i>ability to identify and institute sustainable systems-</i>
1838		<i>based changes to improve patient care.</i>
1839		
1840	VI.A.1.b).(3).(a)	Fellows must have the opportunity to
1841		participate in interprofessional quality
1842		improvement activities. ^(Core)
1843		
1844	VI.A.1.b).(3).(a).(i)	This should include activities aimed at
1845		reducing health care disparities. ^(Detail)
1846		
1847	VI.A.2.	Supervision and Accountability
1848		
1849	VI.A.2.a)	<i>Although the attending physician is ultimately responsible for</i>
1850		<i>the care of the patient, every physician shares in the</i>
1851		<i>responsibility and accountability for their efforts in the</i>
1852		<i>provision of care. Effective programs, in partnership with</i>
1853		<i>their Sponsoring Institutions, define, widely communicate,</i>
1854		<i>and monitor a structured chain of responsibility and</i>
1855		<i>accountability as it relates to the supervision of all patient</i>
1856		<i>care.</i>
1857		
1858		<i>Supervision in the setting of graduate medical education</i>
1859		<i>provides safe and effective care to patients; ensures each</i>
1860		<i>fellow's development of the skills, knowledge, and attitudes</i>

1861 *required to enter the unsupervised practice of medicine; and*
1862 *establishes a foundation for continued professional growth.*

1863
1864 **VI.A.2.a).(1)** **Each patient must have an identifiable and**
1865 **appropriately-credentialed and privileged attending**
1866 **physician (or licensed independent practitioner as**
1867 **specified by the applicable Review Committee) who is**
1868 **responsible and accountable for the patient’s care.**
1869 **(Core)**

1870
1871 **VI.A.2.a).(1).(a)** **This information must be available to fellows,**
1872 **faculty members, other members of the health**
1873 **care team, and patients. (Core)**

1874
1875 **VI.A.2.a).(1).(b)** **Fellows and faculty members must inform each**
1876 **patient of their respective roles in that patient’s**
1877 **care when providing direct patient care. (Core)**

1878
1879 **VI.A.2.b)** ***Supervision may be exercised through a variety of methods.***
1880 ***For many aspects of patient care, the supervising physician***
1881 ***may be a more advanced fellow. Other portions of care***
1882 ***provided by the fellow can be adequately supervised by the***
1883 ***appropriate availability of the supervising faculty member or***
1884 ***fellow, either on site or by means of telecommunication***
1885 ***technology. Some activities require the physical presence of***
1886 ***the supervising faculty member. In some circumstances,***
1887 ***supervision may include post-hoc review of fellow-delivered***
1888 ***care with feedback.***

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

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1891 **VI.A.2.b).(1)** **The program must demonstrate that the appropriate**
1892 **level of supervision in place for all fellows is based on**
1893 **each fellow’s level of training and ability, as well as**
1894 **patient complexity and acuity. Supervision may be**
1895 **exercised through a variety of methods, as appropriate**
1896 **to the situation. (Core)**

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1898 **VI.A.2.b).(2)** **The program must define when physical presence of a**
1899 **supervising physician is required. (Core)**

1900
1901 **VI.A.2.c)** **Levels of Supervision**
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1903		To promote appropriate fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: ^(Core)
1904		
1905		
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1907	VI.A.2.c).(1)	Direct Supervision:
1908		
1909	VI.A.2.c).(1).(a)	the supervising physician is physically present with the fellow during the key portions of the patient interaction; or, ^(Core)
1910		
1911		
1912		
1913	VI.A.2.c).(1).(b)	the supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology. ^(Core)
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1919	VI.A.2.c).(1).(b).(i)	The program must have clear guidelines that delineate which competencies must be demonstrated to determine when a fellow can progress to indirect supervision. ^(Core)
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1924	VI.A.2.c).(1).(b).(i).(a)	These guidelines should stipulate that indirect supervision using telecommunication technology should be limited to patient evaluation for treatment and/or patient follow-up visits and should not be used in the performance of neuroendovascular intervention procedures. ^(Core)
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1934	VI.A.2.c).(1).(b).(ii)	The program director must ensure that clear expectations exist and are communicated to the fellows, and that these expectations outline specific situations in which a fellow still requires direct supervision. ^(Core)
1935		
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1940	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)
1941		
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1946	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)
1947		
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1950	VI.A.2.d)	The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. ^(Core)
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1955	VI.A.2.d).(1)	The program director must evaluate each fellow’s abilities based on specific criteria, guided by the Milestones. <small>(Core)</small>
1956		
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1959	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. <small>(Core)</small>
1960		
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1964	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. <small>(Detail)</small>
1965		
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1970	VI.A.2.e)	Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s). <small>(Core)</small>
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1974	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. <small>(Outcome)‡</small>
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Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.

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1980	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. <small>(Core)</small>
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1985	VI.B.	Professionalism
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1987	VI.B.1.	Programs, in partnership with their Sponsoring Institutions, must educate fellows and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. <small>(Core)</small>
1988		
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1993	VI.B.2.	The learning objectives of the program must:
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1995	VI.B.2.a)	be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; <small>(Core)</small>
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1999	VI.B.2.b)	be accomplished without excessive reliance on fellows to fulfill non-physician obligations; and, <small>(Core)</small>
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Background and Intent: Routine reliance on fellows to fulfill non-physician obligations increases work compression for fellows and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that fellows may be expected to do any of these things on occasion when the need arises, these activities should not be performed by fellows routinely and must be kept to a minimum to optimize fellow education.

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VI.B.2.c) ensure manageable patient care responsibilities. (Core)

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

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

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

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

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

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

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

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

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

2026	VI.B.4.c).(2)	recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. (Outcome)
2027		
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2030	VI.B.4.d)	commitment to lifelong learning; (Outcome)
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2032	VI.B.4.e)	monitoring of their patient care performance improvement indicators; and, (Outcome)
2033		
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2035	VI.B.4.f)	accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)
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2038	VI.B.5.	All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Outcome)
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2044	VI.B.6.	Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, fellows, faculty, and staff. (Core)
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2049	VI.B.7.	Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)
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2055	VI.C.	<p>Well-Being</p> <p><i>Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of fellowship training.</i></p> <p><i>Fellows and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. For example, a culture which encourages covering for colleagues after an illness without the expectation of reciprocity reflects the ideal of professionalism. A positive culture in a clinical learning environment models constructive behaviors, and prepares fellows with the skills and attitudes needed to thrive throughout their careers.</i></p>
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Background and Intent: The ACGME is committed to addressing physician well-being for individuals and as it relates to the learning and working environment. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians' ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and collaboration. Information regarding the ACGME's ongoing efforts in this area is available on the ACGME website.

As these efforts evolve, information will be shared with programs seeking to develop and/or strengthen their own well-being initiatives. In addition, there are many activities that programs can utilize now to assess and support physician well-being. These include culture of safety surveys, ensuring the availability of counseling services, and attention to the safety of the entire health care team.

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

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

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

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise.

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

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

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

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

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

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

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

2129 VI.C.1.e).(3) provide access to confidential, affordable mental
2130 health assessment, counseling, and treatment,
2131 including access to urgent and emergent care 24
2132 hours a day, seven days a week. ^(Core)
2133

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

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

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2135 VI.C.2. There are circumstances in which fellows may be unable to attend
2136 work, including but not limited to fatigue, illness, family
2137 emergencies, and parental leave. Each program must allow an
2138 appropriate length of absence for fellows unable to perform their
2139 patient care responsibilities. ^(Core)
2140

2141 VI.C.2.a) The program must have policies and procedures in place to
2142 ensure coverage of patient care. ^(Core)
2143

2144 VI.C.2.b) These policies must be implemented without fear of negative
2145 consequences for the fellow who is or was unable to provide
2146 the clinical work. ^(Core)
2147

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

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2149 VI.D. Fatigue Mitigation
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2151 VI.D.1. Programs must:

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2153 VI.D.1.a) educate all faculty members and fellows to recognize the
2154 signs of fatigue and sleep deprivation; ^(Core)
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2156 VI.D.1.b) educate all faculty members and fellows in alertness
2157 management and fatigue mitigation processes; and, ^(Core)
2158

2159 VI.D.1.c) encourage fellows to use fatigue mitigation processes to
2160 manage the potential negative effects of fatigue on patient
2161 care and learning. ^(Detail)
2162

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares fellows for

managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

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

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VI.D.2. Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in VI.C.2–VI.C.2.b), in the event that a fellow may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

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

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

VI.E.1. Clinical Responsibilities

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

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

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VI.E.2. Teamwork

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

VI.E.3. Transitions of Care

- 2192 VI.E.3.a) Programs must design clinical assignments to optimize
2193 transitions in patient care, including their safety, frequency,
2194 and structure. ^(Core)
2195
- 2196 VI.E.3.b) Programs, in partnership with their Sponsoring Institutions,
2197 must ensure and monitor effective, structured hand-over
2198 processes to facilitate both continuity of care and patient
2199 safety. ^(Core)
2200
- 2201 VI.E.3.c) Programs must ensure that fellows are competent in
2202 communicating with team members in the hand-over process.
2203 ^(Outcome)
2204
- 2205 VI.E.3.d) Programs and clinical sites must maintain and communicate
2206 schedules of attending physicians and fellows currently
2207 responsible for care. ^(Core)
2208
- 2209 VI.E.3.e) Each program must ensure continuity of patient care,
2210 consistent with the program’s policies and procedures
2211 referenced in VI.C.2-VI.C.2.b), in the event that a fellow may
2212 be unable to perform their patient care responsibilities due to
2213 excessive fatigue or illness, or family emergency. ^(Core)
2214
- 2215 VI.F. Clinical Experience and Education
2216
- 2217 *Programs, in partnership with their Sponsoring Institutions, must design*
2218 *an effective program structure that is configured to provide fellows with*
2219 *educational and clinical experience opportunities, as well as reasonable*
2220 *opportunities for rest and personal activities.*
2221

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

- 2222
- 2223 VI.F.1. Maximum Hours of Clinical and Educational Work per Week
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- 2225 Clinical and educational work hours must be limited to no more than
2226 80 hours per week, averaged over a four-week period, inclusive of all
2227 in-house clinical and educational activities, clinical work done from
2228 home, and all moonlighting. ^(Core)
2229

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

Scheduling

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

Oversight

With increased flexibility introduced into the Requirements, programs permitting this flexibility will need to account for the potential for fellows to remain beyond their assigned work periods when developing schedules, to avoid exceeding the 80-hour maximum weekly limit, averaged over four weeks. The ACGME Review Committees will strictly monitor and enforce compliance with the 80-hour requirement. Where violations of the 80-hour requirement are identified, programs will be subject to citation and at risk for an adverse accreditation action.

Work from Home

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

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a fellow spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the fellow need to report that time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by fellows. The new requirements are not an attempt to micromanage this process. Fellows are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual fellow. Programs will need to factor in time fellows are spending on clinical work at home when schedules are developed to ensure that fellows are not working in

excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that fellows report their time from home and that schedules are structured to ensure that fellows are not working in excess of 80 hours per week, averaged over four weeks.

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

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

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

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)

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

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

Background and Intent: Fellows have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, fellows are encouraged to prioritize sleep over other discretionary activities.

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

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and fellow needs. It is strongly recommended that fellows' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some fellows may prefer to group their days off to have a "golden weekend,"

meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide fellows with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes fellow well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as “one (1) continuous 24-hour period free from all administrative, clinical, and educational activities.”

- 2258
2259 **VI.F.3. Maximum Clinical Work and Education Period Length**
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2261 **VI.F.3.a) Clinical and educational work periods for fellows must not**
2262 **exceed 24 hours of continuous scheduled clinical**
2263 **assignments. (Core)**
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2265 **VI.F.3.a).(1) Up to four hours of additional time may be used for**
2266 **activities related to patient safety, such as providing**
2267 **effective transitions of care, and/or fellow education.**
2268 **(Core)**
2269
2270 **VI.F.3.a).(1).(a) Additional patient care responsibilities must not**
2271 **be assigned to a fellow during this time. (Core)**
2272

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.

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2274 **VI.F.4. Clinical and Educational Work Hour Exceptions**
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2276 **VI.F.4.a) In rare circumstances, after handing off all other**
2277 **responsibilities, a fellow, on their own initiative, may elect to**
2278 **remain or return to the clinical site in the following**
2279 **circumstances:**
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2281 **VI.F.4.a).(1) to continue to provide care to a single severely ill or**
2282 **unstable patient; (Detail)**
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2284 **VI.F.4.a).(2) humanistic attention to the needs of a patient or**
2285 **family; or, (Detail)**
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2287 **VI.F.4.a).(3) to attend unique educational events. (Detail)**
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2289 **VI.F.4.b) These additional hours of care or education will be counted**
2290 **toward the 80-hour weekly limit. (Detail)**
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Background and Intent: This requirement is intended to provide fellows with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a fellow may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Fellows must not be required to stay. Programs allowing fellows to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the fellow and that fellows are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

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

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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VI.F.6. In-House Night Float

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

VI.F.6.a) Fellows must have no more than six consecutive weeks of night float rotations, and no more than four months of night float rotations in total per year. ^(Detail)

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.

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

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

2328	VI.F.8.	At-Home Call
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2330	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)
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2337	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)
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2341	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)
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Background and Intent: This requirement has been modified to specify that clinical work done from home when a fellow is taking at-home call must count toward the 80-hour maximum weekly limit. This change acknowledges the often significant amount of time fellows devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in fellows routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

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

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2348	*Core Requirements:	Statements that define structure, resource, or process elements essential to every graduate medical educational program.
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2351	†Detail Requirements:	Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.
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2356	‡Outcome Requirements:	Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.
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2360	Osteopathic Recognition	
2361		For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements also apply (www.acgme.org/OsteopathicRecognition).
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