Accreditation Council for
Graduate Medical Education

ACGME Program Requirements for Graduate Medical Education in Complex General Surgical Oncology

Proposed focused revision; posted for Review and Comment November 13, 2017

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Complex General Surgical Oncology**
3
4 **One-year Common Program Requirements 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
10 **Introduction**
11
12 **Int.A.** **Residency and fellowship programs are essential dimensions of the**
13 **transformation of the medical student to the independent practitioner along**
14 **the continuum of medical education. They are physically, emotionally, and**
15 **intellectually demanding, and require longitudinally-concentrated effort on**
16 **the part of the resident or fellow.**
17
18 **The specialty education of physicians to practice independently is**
19 **experiential, and necessarily occurs within the context of the health care**
20 **delivery system. Developing the skills, knowledge, and attitudes leading to**
21 **proficiency in all the domains of clinical competency requires the resident**
22 **and fellow physician to assume personal responsibility for the care of**
23 **individual patients. For the resident and fellow, the essential learning**
24 **activity is interaction with patients under the guidance and supervision of**
25 **faculty members who give value, context, and meaning to those**
26 **interactions. As residents and fellows gain experience and demonstrate**
27 **growth in their ability to care for patients, they assume roles that permit**
28 **them to exercise those skills with greater independence. This concept--**
29 **graded and progressive responsibility--is one of the core tenets of**
30 **American graduate medical education. Supervision in the setting of**
31 **graduate medical education has the goals of assuring the provision of safe**
32 **and effective care to the individual patient; assuring each resident's and**
33 **fellow's development of the skills, knowledge, and attitudes required to**
34 **enter the unsupervised practice of medicine; and establishing a foundation**
35 **for continued professional growth.**
36
37 Int.B. A surgical oncologist is a well-qualified surgeon who has obtained additional
38 education and experience in the multidisciplinary approach to the prevention,
39 diagnosis, treatment, and rehabilitation of cancer patients, and who devotes a
40 major portion of his or her professional practice to these activities and to cancer
41 research. Surgical oncologists interact with other oncologic disciplines and
42 provide leadership to the surgical, medical, and lay communities in matters
43 pertaining to cancer.
44
45 Int.C. The educational program in complex general surgical oncology must be 24
46 months in length. (Core)*
47
48 **I. Institutions**
49
50 **I.A. Sponsoring Institution**
51

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52 **One sponsoring institution must assume ultimate responsibility for the**
53 **program, as described in the Institutional Requirements, and this**
54 **responsibility extends to fellow assignments at all participating sites.** (Core)
55
56 **The sponsoring institution and the program must ensure that the program**
57 **director has sufficient protected time and financial support for his or her**
58 **educational and administrative responsibilities to the program.** (Core)
59
60 I.A.1. The complex general surgical oncology program must be affiliated with an
61 ACGME-accredited general surgery program. Sponsorship of the
62 program must be in compliance with the policy detailed in section 15.00 of
63 the ACGME Manual of Policies and Procedures. (Core)
64
65 I.A.2. The complex general surgical oncology program must be affiliated with an
66 ACGME-accredited medical oncology program. (Core)
67
68 **I.B. Participating Sites**
69
70 **I.B.1. There must be a program letter of agreement (PLA) between the**
71 **program and each participating site providing a required**
72 **assignment. The PLA must be renewed at least every five years.** (Core)
73
74 **The PLA should:**
75
76 **I.B.1.a) identify the faculty who will assume both educational and**
77 **supervisory responsibilities for fellows;** (Detail)
78
79 **I.B.1.b) specify their responsibilities for teaching, supervision, and**
80 **formal evaluation of fellows, as specified later in this**
81 **document;** (Detail)
82
83 **I.B.1.c) specify the duration and content of the educational**
84 **experience; and,** (Detail)
85
86 **I.B.1.d) state the policies and procedures that will govern fellow**
87 **education during the assignment.** (Detail)
88
89 **I.B.2. The program director must submit any additions or deletions of**
90 **participating sites routinely providing an educational experience,**
91 **required for all fellows, of one month full time equivalent (FTE) or**
92 **more through the Accreditation Council for Graduate Medical**
93 **Education (ACGME) Accreditation Data System (ADS).** (Core)
94
95 I.B.3. Sites that are integrated with the sponsoring institution must have an
96 integration agreement specifying that the program director must: (Detail)
97
98 I.B.3.a) appoint the members of the faculty at the integrated site; (Detail)
99
100 I.B.3.b) appoint the chief or director of the teaching service at the
101 integrated site; (Detail)
102

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103 I.B.3.c) appoint all fellows in the program; and, (Detail)
104
105 I.B.3.d) determine all rotations and assignments for both fellows and
106 faculty supervisors. (Detail)
107
108 I.B.4. Integrated sites should be in close geographic proximity to allow all
109 fellows to attend joint conferences, basic science lectures, and morbidity
110 and mortality reviews regularly and in a central location. (Detail)
111
112 I.B.5. The Review Committee must approve all integrated sites in advance.
113 (Detail)
114
115 **II. Program Personnel and Resources**
116
117 **II.A. Program Director**
118
119 **II.A.1. There must be a single program director with authority and**
120 **accountability for the operation of the program. The sponsoring**
121 **institution's GMEC must approve a change in program director.** (Core)
122
123 **II.A.1.a) The program director must submit this change to the ACGME**
124 **via the ADS.** (Core)
125
126 **II.A.2. Qualifications of the program director must include:**
127
128 **II.A.2.a) requisite specialty expertise and documented educational**
129 **and administrative experience acceptable to the Review**
130 **Committee;** (Core)
131
132 **II.A.2.b) current certification in the subspecialty by the American**
133 **Board of** Surgery **or subspecialty qualifications that are**
134 **acceptable to the Review Committee;** (Core)
135
136 **II.A.2.c) current medical licensure and appropriate medical staff**
137 **appointment;** (Core)
138
139 II.A.2.d) successful completion of a surgical oncology program sponsored
140 by the Society of Surgical Oncology or a complex general surgical
141 oncology program accredited by the ACGME; and, (Core)
142
143 II.A.2.e) scholarly activity in the areas delineated in Section II.B.7 of this
144 document. (Detail)
145
146 **II.A.3. The program director must administer and maintain an educational**
147 **environment conducive to educating the fellows in each of the**
148 **ACGME competency areas.** (Core)
149
150 **The program director must:**
151
152 **II.A.3.a) prepare and submit all information required and requested by**
153 **the ACGME;** (Core)

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154
155 **II.A.3.b)** **be familiar with and oversee compliance with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;** (Detail)
156
157
158
159 **II.A.3.c)** **obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including:** (Core)
160
161
162
163 **II.A.3.c).(1)** **all applications for ACGME accreditation of new programs;** (Detail)
164
165
166 **II.A.3.c).(2)** **changes in fellow complement;** (Detail)
167
168 **II.A.3.c).(3)** **major changes in program structure or length of training;** (Detail)
169
170
171 **II.A.3.c).(4)** **progress reports requested by the Review Committee;** (Detail)
172
173
174 **II.A.3.c).(5)** **requests for increases or any change to fellow duty hours;** (Detail)
175
176
177 **II.A.3.c).(6)** **voluntary withdrawals of ACGME-accredited programs;** (Detail)
178
179
180 **II.A.3.c).(7)** **requests for appeal of an adverse action; and,** (Detail)
181
182 **II.A.3.c).(8)** **appeal presentations to a Board of Appeal or the ACGME.** (Detail)
183
184
185 **II.A.3.d)** **obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses:** (Detail)
186
187
188
189 **II.A.3.d).(1)** **program citations, and/or,** (Detail)
190
191 **II.A.3.d).(2)** **request for changes in the program that would have significant impact, including financial, on the program or institution.** (Detail)
192
193
194
195 II.A.3.e) develop and implement lines of authority specifying expected reporting relationships for fellows and faculty members to maximize quality care and patient safety. (Detail)
196
197
198
199 II.A.4. The program director must be appointed for a minimum of three years. (Detail)
200
201
202 **II.B. Faculty**
203
204 **II.B.1.** **There must be a sufficient number of faculty with documented**

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205 **qualifications to instruct and supervise all fellows.** (Core)
206
207 **II.B.2.** **The faculty must devote sufficient time to the educational program**
208 **to fulfill their supervisory and teaching responsibilities and**
209 **demonstrate a strong interest in the education of fellows.** (Core)
210
211 **II.B.3.** **The physician faculty must have current certification in the**
212 **subspecialty by the American Board of** Surgery, **or possess**
213 **qualifications judged acceptable to the Review Committee.** (Core)
214
215 II.B.3.a) Surgical faculty members must have successfully completed a
216 complex general surgical oncology program accredited by the
217 ACGME or possess other qualifications found acceptable to the
218 Review Committee. (Core)
219
220 **II.B.4.** **The physician faculty must possess current medical licensure and**
221 **appropriate medical staff appointment.** (Core)
222
223 II.B.5. In addition to the program director, the faculty must include:
224
225 II.B.5.a) at least one full-time physician faculty member for each approved
226 fellowship position whose major function is to support the
227 fellowship program; and, (Core)
228
229 II.B.5.b) at least one faculty member who is ABMS-certified or who
230 possesses qualifications acceptable to the Review Committee in
231 each of the following areas: medical oncology, interventional
232 radiology; and radiation oncology; or possess qualifications
233 acceptable to the Review Committee. (Core)
234
235 II.B.6. Physician faculty members must establish and maintain an environment
236 of inquiry and scholarship with an active research component. (Core)
237
238 II.B.7. Some members of the physician faculty should also demonstrate
239 scholarship by one or more of the following:
240
241 II.B.7.a) peer-reviewed funding; (Detail)
242
243 II.B.7.b) publication of original research or review articles in peer-reviewed
244 journals, or chapters in textbooks; (Detail)
245
246 II.B.7.c) publication or presentation of case reports or clinical series at
247 local, regional, or national professional and scientific society
248 meetings; or, (Detail)
249
250 II.B.7.d) participation in national committees or educational organizations.
251 (Detail)
252
253 II.B.8. Non-physician faculty members must have appropriate qualifications in
254 their fields, and hold appropriate institutional appointments. (Detail)
255

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256 **II.C. Other Program Personnel**
257
258 **The institution and the program must jointly ensure the availability of all**
259 **necessary professional, technical, and clerical personnel for the effective**
260 **administration of the program.** (Core)
261
262 **II.D. Resources**
263
264 **The institution and the program must jointly ensure the availability of**
265 **adequate resources for fellow education, as defined in the specialty**
266 **program requirements.** (Core)
267
268 II.D.1. Each participating site must provide the following resources:
269
270 II.D.1.a) inpatient surgical admissions services; (Core)
271
272 II.D.1.b) intensive care units; and, (Core)
273
274 II.D.1.c) services, including emergency services, interventional radiology,
275 pathology, and radiology. (Core)
276
277 **II.E. Medical Information Access**
278
279 **Fellows must have ready access to specialty-specific and other appropriate**
280 **reference material in print or electronic format. Electronic medical literature**
281 **databases with search capabilities should be available.** (Detail)
282
283 **III. Fellow Appointments**
284
285 **III.A. Eligibility Requirements – Fellowship Programs**
286
287 **All required clinical education for entry into ACGME-accredited fellowship**
288 **programs must be completed in an ACGME-accredited residency program,**
289 **or in a Royal College of Physicians and Surgeons of Canada (RCPSC)-**
290 **accredited or College of Family Physicians Canada (CFPC)-accredited**
291 **residency program located in Canada. (Core)**
292
293 **III.A.1. Fellowship programs must receive verification of each entering**
294 **fellow's level of competency in the required field using ACGME or**
295 **CanMEDS Milestones assessments from the core residency**
296 **program. (Core)**
297
298 **III.A.2. Fellow Eligibility Exception**
299
300 **A Review Committee may grant the following exception to the**
301 **fellowship eligibility requirements:**
302
303 **An ACGME-accredited fellowship program may accept an**
304 **exceptionally qualified applicant**, who does not satisfy the**
305 **eligibility requirements listed in Sections III.A. and III.A.1., but who**

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306 **does meet all of the following additional qualifications and**
307 **conditions:** (Core)
308
309 **III.A.2.a)** **Assessment by the program director and fellowship selection**
310 **committee of the applicant's suitability to enter the program,**
311 **based on prior training and review of the summative**
312 **evaluations of training in the core specialty; and** (Core)
313
314 **III.A.2.b)** **Review and approval of the applicant's exceptional**
315 **qualifications by the GMEC or a subcommittee of the GMEC;**
316 **and** (Core)
317
318 **III.A.2.c)** **Satisfactory completion of the United States Medical**
319 **Licensing Examination (USMLE) Steps 1, 2, and, if the**
320 **applicant is eligible, 3, and;** (Core)
321
322 **III.A.2.d)** **For an international graduate, verification of Educational**
323 **Commission for Foreign Medical Graduates (ECFMG)**
324 **certification; and,** (Core)
325
326 **III.A.2.e)** **Applicants accepted by this exception must complete**
327 **fellowship Milestones evaluation (for the purposes of**
328 **establishment of baseline performance by the Clinical**
329 **Competency Committee), conducted by the receiving**
330 **fellowship program within six weeks of matriculation. This**
331 **evaluation may be waived for an applicant who has**
332 **completed an ACGME International-accredited residency**
333 **based on the applicant's Milestones evaluation conducted at**
334 **the conclusion of the residency program.** (Core)
335
336 **III.A.2.e).(1)** **If the trainee does not meet the expected level of**
337 **Milestones competency following entry into the**
338 **fellowship program, the trainee must undergo a period**
339 **of remediation, overseen by the Clinical Competency**
340 **Committee and monitored by the GMEC or a**
341 **subcommittee of the GMEC. This period of remediation**
342 **must not count toward time in fellowship training.** (Core)
343
344 **** An exceptionally qualified applicant has (1) completed a non-**
345 **ACGME-accredited residency program in the core specialty, and (2)**
346 **demonstrated clinical excellence, in comparison to peers,**
347 **throughout training. Additional evidence of exceptional**
348 **qualifications is required, which may include one of the following:**
349 **(a) participation in additional clinical or research training in the**
350 **specialty or subspecialty; (b) demonstrated scholarship in the**
351 **specialty or subspecialty; (c) demonstrated leadership during or**
352 **after residency training; (d) completion of an ACGME-International-**
353 **accredited residency program.**
354

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355 **III.A.3.** **The Review Committee for** Surgery **does not allow exceptions to the**
356 **Eligibility Requirements for Fellowship Programs in Section III.A.**
357 **(Core)**
358
359 III.A.4. Prior to appointment in the program, fellows must meet at least one of the
360 following:
361
362 III.A.4.a) satisfactory completion of a general surgery program accredited
363 by the ACGME, or a general surgery program located in Canada
364 and accredited by the RCPSC; (Core)
365
366 III.A.4.b) be admissible to examination by the American Board of Surgery;
367 or, (Core)
368
369 III.A.4.c) be certified by the American Board of Surgery. (Core)
370
371 **III.B. Number of Fellows**
372
373 **The program's educational resources must be adequate to support the**
374 **number of fellows appointed to the program.** (Core)
375
376 **III.B.1.** **The program director may not appoint more fellows than approved**
377 **by the Review Committee, unless otherwise stated in the specialty-**
378 **specific requirements.** (Core)
379
380 III.B.2. Both temporary increases longer than three months and permanent
381 increases in fellow complement must be approved in advance by the
382 Review Committee. (Core)
383
384 III.C. The presence of other learners, including residents from other specialties,
385 subspecialty fellows, PhD students, and nurse practitioners, in the program must
386 not interfere with the appointed fellows' education. The program director must
387 report the presence of other learners to the DIO and GMEC in accordance with
388 sponsoring institution guidelines. (Detail)
389
390 **IV. Educational Program**
391
392 **IV.A. The curriculum must contain the following educational components:**
393
394 **IV.A.1.** **Skills and competencies the fellow will be able to demonstrate at the**
395 **conclusion of the program. The program must distribute these skills**
396 **and competencies to fellows and faculty at least annually, in either**
397 **written or electronic form.** (Core)
398
399 **IV.A.2. ACGME Competencies**
400
401 **The program must integrate the following ACGME competencies**
402 **into the curriculum:** (Core)
403
404 **IV.A.2.a) Patient Care and Procedural Skills**
405

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406 **IV.A.2.a).(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.** (Outcome)

411 **IV.A.2.a).(2)** **Fellows must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Fellows:** (Outcome)

416 IV.A.2.a).(2).(a) must demonstrate competence in evaluating patients pre-operatively, making appropriate provisional diagnoses, initiating diagnostic procedures, and forming preliminary treatment plans; (Outcome)

422 IV.A.2.a).(2).(b) must demonstrate competence in oncologic surgical peri-operative management, including: (Outcome)

426 IV.A.2.a).(2).(b).(i) advanced laparoscopic techniques; (Outcome)

428 IV.A.2.a).(2).(b).(ii) broadly-based oncologic surgical procedures, including those for breast, endocrine, gastrointestinal, gynecological, head and neck, melanoma, and sarcoma conditions; (Outcome)

434 IV.A.2.a).(2).(b).(iii) endoscopy; and, (Outcome)

436 IV.A.2.a).(2).(b).(iv) staging methodologies and procedures for all common surgical malignancies. (Outcome)

439 IV.A.2.a).(2).(c) must demonstrate competence in the care of critically-ill surgical patients, including: (Outcome)

442 IV.A.2.a).(2).(c).(i) applying sound principles of pharmacology for each form of therapy; (Outcome)

445 IV.A.2.a).(2).(c).(ii) evaluating and managing patients receiving chemotherapy, hormonal therapy, and immunotherapy; and, (Outcome)

449 IV.A.2.a).(2).(c).(iii) providing supportive care to cancer patients, including pain management. (Outcome)

452 IV.A.2.a).(2).(d) must demonstrate competence in performing cancer-related operative procedures; (Outcome)

455 IV.A.2.a).(2).(d).(i) A minimum of 150 cancer-related operative procedures must be performed. (Core)

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457
458 IV.A.2.a).(2).(e) must demonstrate competence in the surgical management of patients undergoing predominantly medical therapy, including: (Outcome)
459
460
461
462 IV.A.2.a).(2).(e).(i) endoscopic procedures of the aerodigestive tract; (Outcome)
463
464
465 IV.A.2.a).(2).(e).(ii) insertion of indwelling access devices for systemic or regional chemotherapy; (Outcome)
466
467
468 IV.A.2.a).(2).(e).(iii) surgical management of distant metastatic disease, including resection; and, (Outcome)
469
470
471 IV.A.2.a).(2).(e).(iv) minimally invasive surgery, particularly as it applies to the staging of cancer. (Outcome)
472
473
474 IV.A.2.a).(2).(f) must demonstrate competence in providing state-of-the-art surgical care to patients with complex or recurrent neoplasms, including: (Outcome)
475
476
477
478 IV.A.2.a).(2).(f).(i) diagnosis and management of rare or unusual tumors based on knowledge of the natural history of such cancers; and, (Outcome)
479
480
481
482 IV.A.2.a).(2).(f).(i).(a) This must include determining the disease stage and treatment options for individual cancer patients at the time of diagnosis and throughout the disease course. (Detail)
483
484
485
486
487
488 IV.A.2.a).(2).(f).(ii) selecting patients for surgical therapy in combination with other forms of cancer treatment. (Outcome)
489
490
491
492 IV.A.2.a).(2).(f).(ii).(a) This must include performing palliative surgical procedures appropriate for each patient. (Detail)
493
494
495
496 **IV.A.2.b) Medical Knowledge**
497
498 **Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows:** (Outcome)
499
500
501
502
503 IV.A.2.b).(1) must demonstrate competence in their knowledge of:
504
505 IV.A.2.b).(1).(a) the benefits and risks associated with a multidisciplinary approach; (Outcome)
506
507

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508 IV.A.2.b).(1).(b) the fundamental biology of cancer, clinical pharmacology, tumor immunology, and endocrinology, as well as potential complications of multimodality therapy; (Outcome)

513 IV.A.2.b).(1).(b).(i) This must include the biologic, pharmacologic, and physiologic rationale for each form of therapy, as well as the indications, risks, and benefits of regional and systemic therapy in the adjuvant and advanced disease settings. (Detail)

520 IV.A.2.b).(1).(c) non-surgical cancer treatment modalities, including radiotherapy, chemotherapy, immunotherapy, interventional radiology, and endocrine therapy; (Outcome)

525 IV.A.2.b).(1).(d) non-surgical palliative treatments; (Outcome)

527 IV.A.2.b).(1).(e) rehabilitative services in various settings, including reconstructive surgery and physical rehabilitation; and, (Outcome)

531 IV.A.2.b).(1).(f) tumor biology, carcinogenesis, epidemiology, tumor markers, and tumor pathology. (Outcome)

534 **IV.A.2.c) Practice-based Learning and Improvement**

536 **Fellows are expected to develop skills and habits to be able to meet the following goals:**

539 **IV.A.2.c).(1) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;** (Outcome)

543 **IV.A.2.c).(2) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; and,** (Outcome)

547 IV.A.2.c).(3) demonstrate competence in:

549 IV.A.2.c).(3).(a) educating students and physicians in the multimodality management of cancer patients; (Outcome)

553 IV.A.2.c).(3).(b) educating non-physicians (physician assistants, oncology nurses, enterostomal therapists, etc.) in specialized cancer care; and, (Outcome)

557 IV.A.2.c).(3).(c) organizing and conducting cancer-related public education programs. (Outcome)

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559
560 **IV.A.2.d)** **Interpersonal and Communication Skills**
561
562 **Fellows must demonstrate interpersonal and communication**
563 **skills that result in the effective exchange of information and**
564 **collaboration with patients, their families, and health**
565 **professionals.** (Outcome)
566
567 IV.A.2.d).(1) Fellows must demonstrate competence as consultants
568 across the oncologic continuity of care. (Outcome)
569
570 **IV.A.2.e)** **Professionalism**
571
572 **Fellows must demonstrate a commitment to carrying out**
573 **professional responsibilities and an adherence to ethical**
574 **principles.** (Outcome)
575
576 **IV.A.2.f)** **Systems-based Practice**
577
578 **Fellows must demonstrate an awareness of and**
579 **responsiveness to the larger context and system of health**
580 **care, as well as the ability to call effectively on other**
581 **resources in the system to provide optimal health care.** (Outcome)
582
583 IV.A.2.f).(1) Fellows must demonstrate leadership skills to develop and
584 support:
585
586 IV.A.2.f).(1).(a) institutional policies regarding cancer programs and
587 problems; (Outcome)
588
589 IV.A.2.f).(1).(b) institutional programs relating to cancer, including a
590 tumor registry and psychosocial and rehabilitative
591 programs for cancer patients and their families;
592 and, (Outcome)
593
594 IV.A.2.f).(1).(c) interdisciplinary meetings and discussions to
595 include cancer topics, patient care, and the
596 oncology research program. (Outcome)
597
598 IV.A.3. Curriculum Organization and Fellow Experiences
599
600 IV.A.3.a) The curriculum must provide at least:
601
602 IV.A.3.a).(1) 12 months of education in clinical surgical oncology; and,
603 (Core)
604
605 IV.A.3.a).(2) four months of clinical or laboratory research. (Core)
606
607 IV.A.3.a).(2).(a) Fellows must have access to faculty members who
608 can mentor them in basic science research and
609 must have time for such an experience if desired.

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610 (Detail)
611
612 IV.A.3.b) The curriculum should include a minimum of one month each in
613 medical oncology, pathology, and radiation oncology, or provide
614 alternative experiences acceptable to the Review Committee. (Core)
615
616 IV.A.3.c) The didactic curriculum must include:
617
618 IV.A.3.c).(1) a structured series of conferences in the basic and clinical
619 sciences fundamental to oncologic surgery, monthly
620 surgical grand rounds, and twice-monthly morbidity and
621 mortality conferences; (Detail)
622
623 IV.A.3.c).(1).(a) Fellows must organize the formal surgical oncology
624 conferences, grand rounds, and morbidity and
625 mortality conferences, and present a significant
626 share of these conferences. (Detail)
627
628 IV.A.3.c).(2) at least weekly teaching rounds by oncologic surgical
629 faculty members; (Detail)
630
631 IV.A.3.c).(3) education in the basic methodology for conducting clinical
632 trials, including biostatistics, clinical research design,
633 ethics, and implementation of computerized databases;
634 and, (Detail)
635
636 IV.A.3.c).(4) monthly relevant multidisciplinary conferences. (Detail)
637
638 IV.A.3.d) Each organized clinical discussion, round, journal club, and
639 conference must include participation by at least one member of
640 the faculty. (Detail)
641
642 IV.A.3.e) Fellow Experiences
643
644 IV.A.3.e).(1) Clinical assignments should include experiences in general
645 surgical oncology, including breast, gastrointestinal
646 oncology, melanoma, sarcoma, and head and neck. (Core)
647
648 IV.A.3.e).(2) Fellows must provide outpatient follow-up care for surgical
649 patients. (Core)
650
651 IV.A.3.e).(2).(a) Follow-up care should include short- and long-term
652 evaluation and progress, particularly with complex,
653 multidisciplinary cancer management. (Detail)
654
655 IV.A.3.e).(2).(b) Fellows must have documented outpatient
656 experience one day per week. (Detail)
657
658 IV.A.3.e).(3) Each fellow must have experiences acting as a teaching
659 assistant in the operating room when documented
660 operative experience justifies a teaching role. (Detail)

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661
662 IV.A.3.e).(4) Fellows must not share primary responsibility for patients
663 with the surgery chief resident. (Core)
664
665 IV.A.3.e).(5) Fellows must have significant teaching responsibilities for
666 surgery residents, medical students, or other learners. (Core)
667
668 **IV.B. Fellows' Scholarly Activities**
669
670 IV.B.1. Each fellow must complete a course on clinical research on human
671 subjects, such as the courses approved by the National Institutes of
672 Health Office for Human Research Protections, or an institution-based
673 equivalent. (Core)
674
675 IV.B.2. Fellows must demonstrate the ability to: design and implement a
676 prospective data base; conduct clinical cancer research, especially
677 prospective clinical trials; use statistical methods to properly evaluate
678 results of published research studies; guide other learners or other
679 personnel in laboratory or clinical oncology research; and navigate the
680 interface of basic science with clinical cancer care to facilitate
681 translational research. (Outcome)
682
683 **V. Evaluation**
684
685 **V.A. Fellow Evaluation**
686
687 **V.A.1. The program director must appoint the Clinical Competency**
688 **Committee. (Core)**
689
690 **V.A.1.a) At a minimum the Clinical Competency Committee must be**
691 **composed of three members of the program faculty. (Core)**
692
693 **V.A.1.a).(1) The program director may appoint additional members**
694 **of the Clinical Competency Committee.**
695
696 **V.A.1.a).(1).(a) These additional members must be physician**
697 **faculty members from the same program or**
698 **other programs, or other health professionals**
699 **who have extensive contact and experience**
700 **with the program's fellows in patient care and**
701 **other health care settings. (Core)**
702
703 **V.A.1.a).(1).(b) Chief residents who have completed core**
704 **residency programs in their specialty and are**
705 **eligible for specialty board certification may be**
706 **members of the Clinical Competency**
707 **Committee. (Core)**
708
709 **V.A.1.b) There must be a written description of the responsibilities of**
710 **the Clinical Competency Committee. (Core)**
711

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712 **V.A.1.b).(1)** **The Clinical Competency Committee should:**
713
714 **V.A.1.b).(1).(a)** **review all fellow evaluations semi-annually;** **(Core)**
715
716 **V.A.1.b).(1).(b)** **prepare and ensure the reporting of Milestones**
717 **evaluations of each fellow semi-annually to**
718 **ACGME; and,** **(Core)**
719
720 **V.A.1.b).(1).(c)** **advise the program director regarding fellow**
721 **progress, including promotion, remediation,**
722 **and dismissal.** **(Detail)**
723
724 **V.A.2.** **Formative Evaluation**
725
726 **V.A.2.a)** **The faculty must evaluate fellow performance in a timely**
727 **manner.** (Core)
728
729 **V.A.2.b)** **The program must:**
730
731 **V.A.2.b).(1)** **provide objective assessments of competence in**
732 **patient care and procedural skills, medical knowledge,**
733 **practice-based learning and improvement,**
734 **interpersonal and communication skills,**
735 **professionalism, and systems-based practice based**
736 **on the specialty-specific Milestones;** (Core)
737
738 **V.A.2.b).(2)** **use multiple evaluators (e.g., faculty, peers, patients,**
739 **self, and other professional staff); and,** (Detail)
740
741 **V.A.2.b).(3)** **provide each fellow with documented semiannual**
742 **evaluation of performance with feedback.** (Core)
743
744 V.A.2.b).(3).(a) The semiannual review must include review of the
745 fellow's operative data. (Core)
746
747 **V.A.2.c)** **The evaluations of fellow performance must be accessible for**
748 **review by the fellow, in accordance with institutional policy.**
749 (Detail)
750
751 **V.A.3.** **Summative Evaluation**
752
753 **V.A.3.a)** **The specialty-specific Milestones must be used as one of the**
754 **tools to ensure fellows are able to practice core professional**
755 **activities without supervision upon completion of the**
756 **program.** (Core)
757
758 **V.A.3.b)** **The program director must provide a summative evaluation**
759 **for each fellow upon completion of the program.** (Core)
760
761 **This evaluation must:**
762

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763 **V.A.3.b).(1)** **become part of the fellow's permanent record**
764 **maintained by the institution, and must be accessible**
765 **for review by the fellow in accordance with**
766 **institutional policy;** (Detail)
767
768 **V.A.3.b).(2)** **document the fellow's performance during their**
769 **education; and,** (Detail)
770
771 **V.A.3.b).(3)** **verify that the fellow has demonstrated sufficient**
772 **competence to enter practice without direct**
773 **supervision.** (Detail)
774
775 **V.B. Faculty Evaluation**
776
777 **V.B.1.** **At least annually, the program must evaluate faculty performance as**
778 **it relates to the educational program.** (Core)
779
780 **V.B.2.** **These evaluations should include a review of the faculty's clinical**
781 **teaching abilities, commitment to the educational program, clinical**
782 **knowledge, professionalism, and scholarly activities.** (Detail)
783
784 **V.C. Program Evaluation and Improvement**
785
786 **V.C.1.** **The program director must appoint the Program Evaluation**
787 **Committee (PEC).** **(Core)**
788
789 **V.C.1.a)** **The Program Evaluation Committee:**
790
791 **V.C.1.a).(1)** **must be composed of at least two program faculty**
792 **members and should include at least one fellow;** **(Core)**
793
794 **V.C.1.a).(2)** **must have a written description of its responsibilities;**
795 **and,** **(Core)**
796
797 **V.C.1.a).(3)** **should participate actively in:**
798
799 **V.C.1.a).(3).(a)** **planning, developing, implementing, and**
800 **evaluating educational activities of the**
801 **program;** **(Detail)**
802
803 **V.C.1.a).(3).(b)** **reviewing and making recommendations for**
804 **revision of competency-based curriculum goals**
805 **and objectives;** **(Detail)**
806
807 **V.C.1.a).(3).(c)** **addressing areas of non-compliance with**
808 **ACGME standards; and,** **(Detail)**
809
810 **V.C.1.a).(3).(d)** **reviewing the program annually using**
811 **evaluations of faculty, fellows, and others, as**
812 **specified below.** **(Detail)**
813

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814 **V.C.2.** **The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation.** (Core)

The program must monitor and track each of the following areas:

V.C.2.a) **fellow performance;** **(Core)**

V.C.2.b) **faculty development;** **(Core)**

V.C.2.c) **progress on the previous year's action plan(s); and,** **(Core)**

V.C.2.d) graduate performance, including performance of program graduates on the certification examination. (Core)

V.C.2.d).(1) At least 65 percent of a program's graduates from the preceding five years taking the American Board of Surgery Complex General Surgical Oncology examination for the first time must have passed each of the qualifying and certifying examinations. (Outcome)

V.C.3. **The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored.** **(Core)**

V.C.3.a) **The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.** **(Detail)**

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***

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

866 VI.A.1. **Patient Safety and Quality Improvement**

868–876 ***All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare fellows to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by fellows who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.***

878–882 ***Fellows must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating fellows will apply these skills to critique their future unsupervised practice and effect quality improvement measures.***

884–886 ***It is necessary for fellows and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.***

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

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

892–897 ***A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.***

899–902 **VI.A.1.a).(1).(a)** **The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.** (Core)

904–906 **VI.A.1.a).(1).(b)** **The program must have a structure that promotes safe, interprofessional, team-based care.** (Core)

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

910–912 **Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques.** (Core)

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

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915
916 *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.*
925
926 **VI.A.1.a).(3).(a)** **Residents, fellows, faculty members, and other clinical staff members must:**
928
929 **VI.A.1.a).(3).(a).(i)** **know their responsibilities in reporting patient safety events at the clinical site; (Core)**
932
933 **VI.A.1.a).(3).(a).(ii)** **know how to report patient safety events, including near misses, at the clinical site; and, (Core)**
936
937 **VI.A.1.a).(3).(a).(iii)** **be provided with summary information of their institution's patient safety reports. (Core)**
940
941 **VI.A.1.a).(3).(b)** **Fellows must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)**
947
948 **VI.A.1.a).(4)** **Fellow Education and Experience in Disclosure of Adverse Events**
950
951 *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.*
956
957 **VI.A.1.a).(4).(a)** **All fellows must receive training in how to disclose adverse events to patients and families. (Core)**
960
961 **VI.A.1.a).(4).(b)** **Fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)**
964
965 **VI.A.1.b)** **Quality Improvement**

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966
967 **VI.A.1.b).(1)** **Education in Quality Improvement**
968
969 ***A cohesive model of health care includes quality-***
970 ***related goals, tools, and techniques that are necessary***
971 ***in order for health care professionals to achieve***
972 ***quality improvement goals.***
973
974 **VI.A.1.b).(1).(a)** **Fellows must receive training and experience in**
975 **quality improvement processes, including an**
976 **understanding of health care disparities.** (Core)
977
978 **VI.A.1.b).(2)** **Quality Metrics**
979
980 ***Access to data is essential to prioritizing activities for***
981 ***care improvement and evaluating success of***
982 ***improvement efforts.***
983
984 **VI.A.1.b).(2).(a)** **Fellows and faculty members must receive data**
985 **on quality metrics and benchmarks related to**
986 **their patient populations.** (Core)
987
988 **VI.A.1.b).(3)** **Engagement in Quality Improvement Activities**
989
990 ***Experiential learning is essential to developing the***
991 ***ability to identify and institute sustainable systems-***
992 ***based changes to improve patient care.***
993
994 **VI.A.1.b).(3).(a)** **Fellows must have the opportunity to**
995 **participate in interprofessional quality**
996 **improvement activities.** (Core)
997
998 **VI.A.1.b).(3).(a).(i)** **This should include activities aimed at**
999 **reducing health care disparities.** (Detail)
1000
1001 **VI.A.2.** **Supervision and Accountability**
1002
1003 **VI.A.2.a)** ***Although the attending physician is ultimately responsible for***
1004 ***the care of the patient, every physician shares in the***
1005 ***responsibility and accountability for their efforts in the***
1006 ***provision of care. Effective programs, in partnership with***
1007 ***their Sponsoring Institutions, define, widely communicate,***
1008 ***and monitor a structured chain of responsibility and***
1009 ***accountability as it relates to the supervision of all patient***
1010 ***care.***
1011
1012 ***Supervision in the setting of graduate medical education***
1013 ***provides safe and effective care to patients; ensures each***
1014 ***fellow's development of the skills, knowledge, and attitudes***
1015 ***required to enter the unsupervised practice of medicine; and***
1016 ***establishes a foundation for continued professional growth.***

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1017
1018 **VI.A.2.a).(1)** **Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care.** **(Core)**
1019
1020
1021
1022
1023
1024
1025 **VI.A.2.a).(1).(a)** **This information must be available to fellows, faculty members, other members of the health care team, and patients.** **(Core)**
1026
1027
1028
1029 **VI.A.2.a).(1).(b)** **Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.** **(Core)**
1030
1031
1032
1033 **VI.A.2.b)** ***Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback.***
1034
1035
1036
1037
1038
1039
1040
1041
1042
1043
1044 **VI.A.2.b).(1)** **The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.** **(Core)**
1045
1046
1047
1048
1049
1050
1051 **VI.A.2.c)** **Levels of Supervision**
1052
1053 **To promote oversight of fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:** **(Core)**
1054
1055
1056
1057 **VI.A.2.c).(1)** **Direct Supervision – the supervising physician is physically present with the fellow and patient.** **(Core)**
1058
1059
1060 **VI.A.2.c).(2)** **Indirect Supervision:**
1061
1062 **VI.A.2.c).(2).(a)** **with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.** **(Core)**
1063
1064
1065
1066
1067

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1068 **VI.A.2.c).(2).(b)** **with Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.** (Core)

1075 **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)

1079 **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)

1084 **VI.A.2.d).(1)** **The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones.** (Core)

1088 **VI.A.2.d).(2)** **Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow.** (Core)

1093 **VI.A.2.d).(3)** **Fellows should serve in a supervisory role to residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.** (Detail)

1099 **VI.A.2.e)** **Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s).** (Core)

1103 **VI.A.2.e).(1)** **Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence.** (Outcome)

1108 **VI.A.2.f)** **Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each fellow and to delegate to the fellow the appropriate level of patient care authority and responsibility.** (Core)

1113 **VI.B.** **Professionalism**

1115 **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**

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1119 **patients. (Core)**
1120
1121 **VI.B.2.** **The learning objectives of the program must:**
1122
1123 **VI.B.2.a)** **be accomplished through an appropriate blend of supervised**
1124 **patient care responsibilities, clinical teaching, and didactic**
1125 **educational events; (Core)**
1126
1127 **VI.B.2.b)** **be accomplished without excessive reliance on fellows to**
1128 **fulfill non-physician obligations; and, (Core)**
1129
1130 **VI.B.2.c)** **ensure manageable patient care responsibilities. (Core)**
1131
1132 **VI.B.3.** **The program director, in partnership with the Sponsoring Institution,**
1133 **must provide a culture of professionalism that supports patient**
1134 **safety and personal responsibility. (Core)**
1135
1136 **VI.B.4.** **Fellows and faculty members must demonstrate an understanding**
1137 **of their personal role in the:**
1138
1139 **VI.B.4.a)** **provision of patient- and family-centered care; (Outcome)**
1140
1141 **VI.B.4.b)** **safety and welfare of patients entrusted to their care,**
1142 **including the ability to report unsafe conditions and adverse**
1143 **events; (Outcome)**
1144
1145 **VI.B.4.c)** **assurance of their fitness for work, including: (Outcome)**
1146
1147 **VI.B.4.c).(1)** **management of their time before, during, and after**
1148 **clinical assignments; and, (Outcome)**
1149
1150 **VI.B.4.c).(2)** **recognition of impairment, including from illness,**
1151 **fatigue, and substance use, in themselves, their peers,**
1152 **and other members of the health care team. (Outcome)**
1153
1154 **VI.B.4.d)** **commitment to lifelong learning; (Outcome)**
1155
1156 **VI.B.4.e)** **monitoring of their patient care performance improvement**
1157 **indicators; and, (Outcome)**
1158
1159 **VI.B.4.f)** **accurate reporting of clinical and educational work hours,**
1160 **patient outcomes, and clinical experience data. (Outcome)**
1161
1162 **VI.B.5.** **All fellows and faculty members must demonstrate responsiveness**
1163 **to patient needs that supersedes self-interest. This includes the**
1164 **recognition that under certain circumstances, the best interests of**
1165 **the patient may be served by transitioning that patient's care to**
1166 **another qualified and rested provider. (Outcome)**
1167
1168 **VI.B.6.** **Programs must provide a professional, respectful, and civil**
1169 **environment that is free from mistreatment, abuse, or coercion of**

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1170 **students, residents/fellows, faculty, and staff. Programs, in**
1171 **partnership with their Sponsoring Institutions, should have a**
1172 **process for education of fellows and faculty regarding**
1173 **unprofessional behavior and a confidential process for reporting,**
1174 **investigating, and addressing such concerns.** (Core)
1175
1176 **VI.C. Well-Being**
1177
1178 ***In the current health care environment, fellows and faculty members are at***
1179 ***increased risk for burnout and depression. Psychological, emotional, and***
1180 ***physical well-being are critical in the development of the competent,***
1181 ***caring, and resilient physician. Self-care is an important component of***
1182 ***professionalism; it is also a skill that must be learned and nurtured in the***
1183 ***context of other aspects of fellowship training. Programs, in partnership***
1184 ***with their Sponsoring Institutions, have the same responsibility to address***
1185 ***well-being as they do to evaluate other aspects of fellow competence.***
1186
1187 **VI.C.1. This responsibility must include:**
1188
1189 **VI.C.1.a) efforts to enhance the meaning that each fellow finds in the**
1190 **experience of being a physician, including protecting time**
1191 **with patients, minimizing non-physician obligations,**
1192 **providing administrative support, promoting progressive**
1193 **autonomy and flexibility, and enhancing professional**
1194 **relationships;** (Core)
1195
1196 **VI.C.1.b) attention to scheduling, work intensity, and work**
1197 **compression that impacts fellow well-being;** (Core)
1198
1199 **VI.C.1.c) evaluating workplace safety data and addressing the safety of**
1200 **fellows and faculty members;** (Core)
1201
1202 **VI.C.1.d) policies and programs that encourage optimal fellow and**
1203 **faculty member well-being; and,** (Core)
1204
1205 **VI.C.1.d).(1) Fellows must be given the opportunity to attend**
1206 **medical, mental health, and dental care appointments,**
1207 **including those scheduled during their working hours.**
1208 (Core)
1209
1210 **VI.C.1.e) attention to fellow and faculty member burnout, depression,**
1211 **and substance abuse. The program, in partnership with its**
1212 **Sponsoring Institution, must educate faculty members and**
1213 **fellows in identification of the symptoms of burnout,**
1214 **depression, and substance abuse, including means to assist**
1215 **those who experience these conditions. Fellows and faculty**
1216 **members must also be educated to recognize those**
1217 **symptoms in themselves and how to seek appropriate care.**
1218 **The program, in partnership with its Sponsoring Institution,**
1219 **must:** (Core)
1220

1221 **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 resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence;** (Core)

1228 **VI.C.1.e).(2)** **provide access to appropriate tools for self-screening; and,** (Core)

1231 **VI.C.1.e).(3)** **provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.** (Core)

1236 **VI.C.2.** **There are circumstances in which fellows may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a fellow may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the fellow who is unable to provide the clinical work.** (Core)

1245 **VI.D.** **Fatigue Mitigation**

1247 **VI.D.1.** **Programs must:**

1249 **VI.D.1.a)** **educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;** (Core)

1252 **VI.D.1.b)** **educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,** (Core)

1255 **VI.D.1.c)** **encourage fellows to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.** (Detail)

1259 **VI.D.2.** **Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a fellow may be unable to perform their patient care responsibilities due to excessive fatigue.** (Core)

1264 **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)

1268 **VI.E.** **Clinical Responsibilities, Teamwork, and Transitions of Care**

1270 **VI.E.1.** **Clinical Responsibilities**

1271

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1272 **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)

1276 VI.E.1.a) As fellows progress through levels of increasing competence and responsibility, work assignments must keep pace with their level of advancement. (Detail)

1280 **VI.E.2. Teamwork**

1282 **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 specialty and larger health system.** (Core)

1287 VI.E.2.a) During the fellow education process, surgical teams should be made up of attending surgeons, fellows, residents at various PG levels, medical students (when appropriate), and other health care providers. (Detail)

1292 VI.E.2.b) The work of the caregiver team should be assigned to team members based on each member's level of education, experience, and competence. (Detail)

1296 VI.E.2.c) Fellows must collaborate with fellow surgical residents, and especially with faculty members, other physicians outside of their subspecialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population. (Detail)

1302 VI.E.2.d) Fellows must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the health care team so that patient care is not compromised. (Detail)

1310 **VI.E.3. Transitions of Care**

1312 **VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.** (Core)

1316 **VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.** (Core)

1321 **VI.E.3.c) Programs must ensure that fellows are competent in communicating with team members in the hand-over process.**

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1323 (Outcome)
1324
1325 **VI.E.3.d)** **Programs and clinical sites must maintain and communicate**
1326 **schedules of attending physicians and fellows currently**
1327 **responsible for care.** (Core)
1328
1329 **VI.E.3.e)** **Each program must ensure continuity of patient care,**
1330 **consistent with the program's policies and procedures**
1331 **referenced in VI.C.2, in the event that a fellow may be unable**
1332 **to perform their patient care responsibilities due to excessive**
1333 **fatigue or illness, or family emergency.** (Core)
1334
1335 **VI.F.** **Clinical Experience and Education**
1336
1337 ***Programs, in partnership with their Sponsoring Institutions, must design***
1338 ***an effective program structure that is configured to provide fellows with***
1339 ***educational and clinical experience opportunities, as well as reasonable***
1340 ***opportunities for rest and personal activities.***
1341
1342 **VI.F.1.** **Maximum Hours of Clinical and Educational Work per Week**
1343
1344 **Clinical and educational work hours must be limited to no more than**
1345 **80 hours per week, averaged over a four-week period, inclusive of all**
1346 **in-house clinical and educational activities, clinical work done from**
1347 **home, and all moonlighting.** (Core)
1348
1349 **VI.F.2.** **Mandatory Time Free of Clinical Work and Education**
1350
1351 **VI.F.2.a)** **The program must design an effective program structure that**
1352 **is configured to provide fellows with educational**
1353 **opportunities, as well as reasonable opportunities for rest**
1354 **and personal well-being.** (Core)
1355
1356 **VI.F.2.b)** **Fellows should have eight hours off between scheduled**
1357 **clinical work and education periods.** (Detail)
1358
1359 **VI.F.2.b).(1)** **There may be circumstances when fellows choose to**
1360 **stay to care for their patients or return to the hospital**
1361 **with fewer than eight hours free of clinical experience**
1362 **and education. This must occur within the context of**
1363 **the 80-hour and the one-day-off-in-seven**
1364 **requirements.** (Detail)
1365
1366 **VI.F.2.c)** **Fellows must have at least 14 hours free of clinical work and**
1367 **education after 24 hours of in-house call.** (Core)
1368
1369 **VI.F.2.d)** **Fellows must be scheduled for a minimum of one day in**
1370 **seven free of clinical work and required education (when**
1371 **averaged over four weeks). At-home call cannot be assigned**
1372 **on these free days.** (Core)
1373

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1374 **VI.F.3. Maximum Clinical Work and Education Period Length**
1375
1376 **VI.F.3.a) Clinical and educational work periods for fellows must not**
1377 **exceed 24 hours of continuous scheduled clinical**
1378 **assignments.** **(Core)**
1379
1380 **VI.F.3.a).(1) Up to four hours of additional time may be used for**
1381 **activities related to patient safety, such as providing**
1382 **effective transitions of care, and/or fellow education.**
1383 **(Core)**
1384
1385 **VI.F.3.a).(1).(a) Additional patient care responsibilities must not**
1386 **be assigned to a fellow during this time.** **(Core)**
1387
1388 **VI.F.4. Clinical and Educational Work Hour Exceptions**
1389
1390 **VI.F.4.a) In rare circumstances, after handing off all other**
1391 **responsibilities, a fellow, on their own initiative, may elect to**
1392 **remain or return to the clinical site in the following**
1393 **circumstances:**
1394
1395 **VI.F.4.a).(1) to continue to provide care to a single severely ill or**
1396 **unstable patient;** **(Detail)**
1397
1398 **VI.F.4.a).(2) humanistic attention to the needs of a patient or**
1399 **family; or,** **(Detail)**
1400
1401 **VI.F.4.a).(3) to attend unique educational events.** **(Detail)**
1402
1403 **VI.F.4.b) These additional hours of care or education will be counted**
1404 **toward the 80-hour weekly limit.** **(Detail)**
1405
1406 **VI.F.4.c) A Review Committee may grant rotation-specific exceptions**
1407 **for up to 10 percent or a maximum of 88 clinical and**
1408 **educational work hours to individual programs based on a**
1409 **sound educational rationale.**
1410
1411 The Review Committee for General Surgery will not consider
1412 requests for exceptions to the 80-hour limit to the fellow's work
1413 week.
1414
1415 **VI.F.4.c).(1) In preparing a request for an exception, the program**
1416 **director must follow the clinical and educational work**
1417 **hour exception policy from the *ACGME Manual of***
1418 ***Policies and Procedures*.** **(Core)**
1419
1420 **VI.F.4.c).(2) Prior to submitting the request to the Review**
1421 **Committee, the program director must obtain approval**
1422 **from the Sponsoring Institution's GMEC and DIO.** **(Core)**
1423
1424 **VI.F.5. Moonlighting**

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1425
1426 **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)**
1430
1431 **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)**
1434
1435 **VI.F.6.** **In-House Night Float**
1436
1437 **Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.** **(Core)**
1439
1440 VI.F.6.a) The total amount of night float for any fellow must be no more than two months per PG year. (Detail)
1442
1443 **VI.F.7.** **Maximum In-House On-Call Frequency**
1444
1445 **Fellows must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).** **(Core)**
1447
1448 **VI.F.8.** **At-Home Call**
1449
1450 **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)**
1456
1457 **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)**
1460
1461 **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)**
1465
1466 **VI.F.9.** **Maximum Frequency of In-House Night Float**
1467
1468 **Fellows must not be scheduled for more than six consecutive nights of night float.** (Core)
1470
1471 ***
1472
1473 ***Core Requirements:** Statements that define structure, resource, or process elements essential to every
1474 graduate medical educational program.
1475 **Detail Requirements:** Statements that describe a specific structure, resource, or process, for achieving

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1476 compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance
1477 with the Outcome Requirements may utilize alternative or innovative approaches to meet Core
1478 Requirements.
1479 **Outcome Requirements:** Statements that specify expected measurable or observable attributes
1480 (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical
1481 education.
1482
1483 **Osteopathic Recognition**
1484 For programs seeking Osteopathic Recognition for the entire program, or for a track within the program,
1485 the Osteopathic Recognition Requirements are also applicable.
1486 (http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requiremen
1487 ts.pdf)

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