Accreditation Council for
Graduate Medical Education

ACGME Program Requirements for Graduate Medical Education in Pediatric Urology

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ACGME Program Requirements for Graduate Medical Education
in Pediatric Urology

One-year Common Program Requirements are in BOLD

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

Introduction

Int.A. **Residency and fellowship programs are essential dimensions of the transformation of the medical student to the independent practitioner along the continuum of medical education. They are physically, emotionally, and intellectually demanding, and require longitudinally-concentrated effort on the part of the resident or fellow.**

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident and fellow physician to assume personal responsibility for the care of individual patients. For the resident and fellow, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents and fellows gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept--graded and progressive responsibility--is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's and fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int.B. Definition and Scope of the Fellowship

Fellowship education in pediatric urology consists of the diagnosis, management, and treatment of fetal, perinatal, ~~child~~childhood, pre-adolescent, and adolescent genitourinary and adrenal abnormalities and diseases, and the promotion of health with prevention of disease. This education includes~~ specifically:~~ experience with fetal and genetic evaluation; pediatric endocrinology; issues of renal disease, such as chronic renal insufficiency, and transplantation; congenital and acquired neurological diseases affecting the urinary tract, such as spina bifida and neurogenic bladder; ~~the~~ treatment and management of congenital genitourinary abnormalities~~,~~; and reconstructive urology~~. For the full integration of patient management in these areas, the following are required: education in advanced imaging of the pediatric genitourinary tract; radiation and imaging safety risks; pharmacology and safety of commonly used agents, and pediatric pain management.~~ across all ages. (Core)*

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Int.C. Duration of Education

~~The length of a pediatric urology clinical program is one year of clinical education.~~ The educational program in pediatric urology must be 12 months in length. (Core)

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to fellow assignments at all participating sites. (Core)

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program. (Core)

I.A.1. ~~Sponsorship of the program must be in compliance with the policy detailed in section 15.00 of the ACGME Manual of Policies and Procedures. (Core)~~

I.A.2. The ~~pediatric urology~~ program must be centered at a children's hospital or a medical center with pediatric medical, surgical, and imaging capabilities, ~~subspecialties~~ and must be affiliated with an ACGME-accredited urology program. (Core)

I.A.3. ~~To be accredited, the pediatric urology program must have written documentation of an educational relationship from the ACGME-accredited core urology program director. (Core)~~

I.B. Participating Sites

I.B.1. **There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.** (Core)

The PLA should:

I.B.1.a) **identify the faculty who will assume both educational and supervisory responsibilities for fellows;** (Detail)

I.B.1.b) **specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document;** (Detail)

I.B.1.c) **specify the duration and content of the educational experience; and,** (Detail)

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I.B.1.d) **state the policies and procedures that will govern fellow education during the assignment.** (Detail)

I.B.2. **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 Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).** (Core)

I.B.2.a) ~~Participating sites offering three months or more of education for the program must be approved in advance by the Review Committee. (Detail)~~

I.B.3. Assignments at participating sites must be for a minimum of one month to ensure a quality educational experience, and must provide sufficient opportunity for continuity of care. (Core)

II. Program Personnel and Resources

II.A. Program Director

II.A.1. **There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director.** (Core)

II.A.1.a) **The program director must submit this change to the ACGME via the ADS.** (Core)

II.A.1.b) ~~When the sponsoring institution also sponsors a core urology program, the pediatric urology program director must be involved in the education of the core urology program. (Core)~~

II.A.1.c) ~~The minimum term of appointment for the~~The program director ~~should be~~must continue in his or her position for a minimum of ~~three~~six years to provide for educational stability. (Core)

II.A.2. **Qualifications of the program director must include:**

II.A.2.a) **requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;** (Core)

II.A.2.b) **current certification in the subspecialty of Pediatric Urology by the American Board of** Urology**, or subspecialty qualifications that are acceptable to the Review Committee;**(Core)

II.A.2.c) **current medical licensure and appropriate medical staff appointment; and,** (Core)

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II.A.2.d) a minimum of four years of experience in urology following residency or qualifications acceptable to the Review Committee. (Core)

II.A.3. **The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas.** (Core)

The program director must:

II.A.3.a) **prepare and submit all information required and requested by the ACGME;** (Core)

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)

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)

II.A.3.c).(1) **all applications for ACGME accreditation of new programs;** (Detail)

II.A.3.c).(2) **changes in fellow complement;** (Detail)

II.A.3.c).(2).(a) ~~Any permanent or temporary increase in resident complement must be approved in advance by the Review Committee. (Core)~~

II.A.3.c).(3) **major changes in program structure or length of training;** (Detail)

II.A.3.c).(4) **progress reports requested by the Review Committee;** (Detail)

II.A.3.c).(5) **requests for increases or any change to fellow duty hours;** (Detail)

II.A.3.c).(6) **voluntary withdrawals of ACGME-accredited programs;** (Detail)

II.A.3.c).(7) **requests for appeal of an adverse action; and,** (Detail)

II.A.3.c).(8) **appeal presentations to a Board of Appeal or the ACGME.** (Detail)

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)

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II.A.3.d).(1) **program citations, and/or,** (Detail)

II.A.3.d).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.** (Detail)

II.A.3.e) select and supervise the local site director and faculty at each participating site; and, (Core)

II.A.3.f) ~~confirm and document the fellow data entry into the ACGME web-based operative log and submission of the resident's final log to the ACGME on graduation; (Core)~~

II.A.3.g) ~~ensure that conferences reflect multidisciplinary patient evaluation including uroradiologic and journal review; (Core)~~

II.A.3.h) ~~ensure that morbidity and mortality conferences for all participating sites, urological imaging, and journal review~~ be ~~documented; (Core)~~

II.A.3.i) ~~ensure that a list of conferences is maintained and available at the site visit. The list must include the names of those attending, the subjects discussed, and the principal speaker. Attendance must be documented; and, (Core)~~

II.A.3.j) be meaningfully involved in the core urology residency program. (~~Detail~~Core)

II.B. Faculty

II.B.1. **There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.** (Core)

II.B.2. **The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in the education of fellows.** (Core)

II.B.2.a) ~~There should~~In addition to the program director, there must be a minimum of one full-time pediatric urology faculty member~~, in addition to the program director,~~ for each pediatric urology ~~resident~~fellow~~, i.e., there should be two faculty members to one pediatric urology resident~~. (Core)

II.B.3. **The physician faculty must have current certification in the subspecialty of** Pediatric Urology by the American Board of Urology**, or possess qualifications judged acceptable to the Review Committee.** (Core)

II.B.4. **The physician faculty must possess current medical licensure and appropriate medical staff appointment.** (Core)

II.B.4.a) ~~A faculty member must supervise each conference. (Detail)~~

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program. (Core)

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for fellow education, as defined in the specialty program requirements. (Core)

II.D.1. The program should have technologically-current and pediatric-specific diagnostic and treatment facilities, ~~e.g.,~~such as body-imaging and urodynamics equipment, interventional radiology, and anesthesia and pain management suitable for the care of pediatric patients. (Core)

II.D.2. The program must ensure adequate space and equipment for the educational program, ~~i.e.,~~ such as meeting rooms and classrooms, educational aides, and sufficient office space for fellows and staff members. (Core)

II.D.3. The ~~sponsoring institution~~Sponsoring Institution must provide a sufficient volume and variety of pediatric urology experience to meet the needs of the ~~pediatric urology~~ fellows' education without compromising the quality of resident education in the core urology program. (Core)

II.D.4. ~~To be considered for accreditation, the sponsoring institution should~~The program must have the following resources available for fellow education: a broad spectrum of urologic diseases; and a sufficient volume and broad variety of pediatric urology surgical procedures consisting of a minimum of 500 procedures per year and 2000 pediatric urologic outpatient visits per year, including urology subspecialty clinics. (Core)

II.E. Medical Information Access

Fellows must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available. (Detail)

III. Fellow Appointments

III.A. Eligibility Requirements – Fellowship Programs

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

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305
306 Fellows must have successfully completed a urology residency program
307 accredited by the ACGME or the RCPSC. (Core)
308
309 **III.A.1.** **Fellowship programs must receive verification of each entering**
310 **fellow's level of competency in the required field using ACGME or**
311 **CanMEDS Milestones assessments from the core residency**
312 **program. (Core)**
313
314 **III.A.2.** **Fellow Eligibility Exception**
315
316 **A Review Committee may grant the following exception to the**
317 **fellowship eligibility requirements:**
318
319 **An ACGME-accredited fellowship program may accept an**
320 **exceptionally qualified applicant**, who does not satisfy the**
321 **eligibility requirements listed in Sections III.A. and III.A.1., but who**
322 **does meet all of the following additional qualifications and**
323 **conditions: (Core)**
324
325 **III.A.2.a)** **Assessment by the program director and fellowship selection**
326 **committee of the applicant's suitability to enter the program,**
327 **based on prior training and review of the summative**
328 **evaluations of training in the core specialty; and (Core)**
329
330 **III.A.2.b)** **Review and approval of the applicant's exceptional**
331 **qualifications by the GMEC or a subcommittee of the GMEC;**
332 **and (Core)**
333
334 **III.A.2.c)** **Satisfactory completion of the United States Medical**
335 **Licensing Examination (USMLE) Steps 1, 2, and, if the**
336 **applicant is eligible, 3, and; (Core)**
337
338 **III.A.2.d)** **For an international graduate, verification of Educational**
339 **Commission for Foreign Medical Graduates (ECFMG)**
340 **certification; and, (Core)**
341
342 **III.A.2.e)** **Applicants accepted by this exception must complete**
343 **fellowship Milestones evaluation (for the purposes of**
344 **establishment of baseline performance by the Clinical**
345 **Competency Committee), conducted by the receiving**
346 **fellowship program within six weeks of matriculation. This**
347 **evaluation may be waived for an applicant who has**
348 **completed an ACGME International-accredited residency**
349 **based on the applicant's Milestones evaluation conducted at**
350 **the conclusion of the residency program. (Core)**
351
352 **III.A.2.e).(1)** **If the trainee does not meet the expected level of**
353 **Milestones competency following entry into the**
354 **fellowship program, the trainee must undergo a period**
355 **of remediation, overseen by the Clinical Competency**

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Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training. (Core)

**** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, 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; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.**

III.A.3. **The Review Committee for** Urology **does not allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A.** (Core)

III.B. Number of Fellows

The program's educational resources must be adequate to support the number of fellows appointed to the program. (Core)

III.B.1. **The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements.** (Core)

III.B.2. ~~Transfers in 12-month programs are discouraged. (Detail)~~The transfer of a fellow from one program to another must be reported to the Review Committee. (Core)

III.B.3. ~~In any given year, the program may not graduate more pediatric urology surgery fellows than the number approved by the Review Committee. Any change in the number of fellows, whether permanent or temporary, must be approved in advance by the Review Committee. Such requests must be based upon a sufficient educational rationale that considers the educational quality of the current pediatric urology fellows admitted to the program. (Core)~~

III.B.4. ~~At the time of the site visit, the operative log experiences of each additional resident or fellow who is provided with experience in pediatric urology will be reviewed. (Detail)~~

IV. Educational Program

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

IV.A.1. **Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills**

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and competencies to fellows and faculty at least annually, in either written or electronic form. (Core)

IV.A.2. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: (Core)

IV.A.2.a) Patient Care and Procedural Skills

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)

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)

must demonstrate competence in:

IV.A.2.a).(2).(a) ~~the~~all surgical aspects of pediatric urology ~~which~~that must be documented ~~in an accurate, comprehensive, operative log maintained~~ by the fellow in the ACGME Case Log System and reviewed by the program director quarterly; (Outcome)

IV.A.2.a).(2).(a).(i) All operative procedures in which the pediatric urology fellow acts as a surgeon, assistant, or teaching assistant should be separately documented. (~~Core~~Detail)

IV.A.2.a).(2).(a).(ii) Each graduating fellow must perform the minimum number of essential operative cases and case categories as established by the Review Committee. (Core)

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

IV.A.2.a).(2).(c) imaging modalities used in the care of pediatric patients ~~(~~, including ~~but not limited to:~~ ultrasonography, fluoroscopy, computed tomography, magnetic resonance imaging, and nuclear scintigraphy~~)~~; (Outcome)

IV.A.2.a).(2).(d) performance and evaluation of urodynamic studies; (Outcome)

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IV.A.2.a).(2).(e) multidisciplinary management of patients with urologic tumors; (Outcome)

IV.A.2.a).(2).(f) multidisciplinary management of patients with urologic trauma; (Outcome)

IV.A.2.a).(2).(g) multidisciplinary management of nephrological and endocrinologic (adrenal) disease; (Outcome)

IV.A.2.a).(2).(h) pre- and post-operative management and treatment of severely ill neonates, children, pre-adolescents, and adolescents with genitourinary problems who require intensive medical care (i.e., neonatal or pediatric intensive care unit management); (Outcome)

IV.A.2.a).(2).(i) multidisciplinary management of myelomeningocele and other neuropathic bladder entities; (Outcome)

IV.A.2.a).(2).(j) multidisciplinary management of patients with problems relating to sexual development and medical aspects of disorders of sex development (DSD) states; (Outcome)

IV.A.2.a).(2).(k) performance of prenatal and postnatal genetic counseling for genitourinary tract anomalies; and, (Outcome)

IV.A.2.a).(2).(l) management of genitourinary infections. (Outcome)

IV.A.2.b) **Medical Knowledge**

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

IV.A.2.b).(1) must demonstrate the ability to integrate ~~core~~ knowledge ~~in~~ of the following into care of the pediatric urology patient: ~~pediatric urology as detailed in the curriculum, and also demonstrate specialty-specific additional knowledge in fetal and perinatal nephrology, endocrinology, radiation safety, appropriate pain management, chronic renal diseases, and pharmacology of commonly used drugs and chemicals.~~ (Outcome)

IV.A.2.b).(1).(a) pediatric diseases and diagnoses, including: (Outcome)

IV.A.2.b).(1).(a).(i) endocrinology; (Outcome)

IV.A.2.b).(1).(a).(ii) nephrology; and, (Outcome)

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508 IV.A.2.b).(1).(a).(iii) acute and chronic renal diseases. (Outcome)
509
510 IV.A.2.b).(1).(b) quality and patient safety measures; (Outcome)
511
512 IV.A.2.b).(1).(c) imagining of the pediatric genitourinary tract with a
513 focus on radiation and imagining safety risks;
514 (Outcome)
515
516 IV.A.2.b).(1).(d) pharmacology and the safe use of commonly used
517 agents; and, (Outcome)
518
519 IV.A.2.b).(1).(e) safe use of medicine in pediatric pain management.
520 (Outcome)
521
522 **IV.A.2.c) Practice-based Learning and Improvement**
523
524 **Fellows are expected to develop skills and habits to be able**
525 **to meet the following goals:**
526
527 **IV.A.2.c).(1) systematically analyze practice using quality**
528 **improvement methods, and implement changes with**
529 **the goal of practice improvement; and,** (Outcome)
530
531 **IV.A.2.c).(2) locate, appraise, and assimilate evidence from**
532 **scientific studies related to their patients' health**
533 **problems;** (Outcome)
534
535 **IV.A.2.d) Interpersonal and Communication Skills**
536
537 **Fellows must demonstrate interpersonal and communication**
538 **skills that result in the effective exchange of information and**
539 **collaboration with patients, their families, and health**
540 **professionals.** (Outcome)
541
542 **IV.A.2.e) Professionalism**
543
544 **Fellows must demonstrate a commitment to carrying out**
545 **professional responsibilities and an adherence to ethical**
546 **principles.** (Outcome)
547
548 **IV.A.2.f) Systems-based Practice**
549
550 **Fellows must demonstrate an awareness of and**
551 **responsiveness to the larger context and system of health**
552 **care, as well as the ability to call effectively on other**
553 **resources in the system to provide optimal health care.**
554 (Outcome)
555
556 IV.A.3. Curriculum Organization and Fellow Experiences
557
558 IV.A.3.a) Didactic conferences must reflect patient evaluation and include:

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IV.A.3.a).(1).(a) morbidity and mortality; (Core)

IV.A.3.a).(1).(b) multidisciplinary urological imaging review; and, (Core)

IV.A.3.a).(1).(c) journal review. (Core)

IV.A.3.a).(2) A faculty member must supervise each conference. (Core)

IV.A.3.a).(3) A list of conferences must be maintained and must include the date, conference topic, the name of the presenter(s), and the names of the faculty members and fellows present at each. (Core)

IV.A.3.b) Clinical education must consist of 12 consecutive months of pediatric urology. (Core)

IV.A.3.b).(1) Fellows must work in multidisciplinary teams to learn a wide range of clinical pediatric urology. (Core)

IV.A.3.b).(2) Fellows should attend a minimum of four clinic sessions per month. (Detail)

IV.B. Fellows' Scholarly Activities

IV.B.1. Formal research activity must not occur during the fellowship (i.e., clinical year). (Core)

IV.B.2. Fellows' ~~documentation of their~~ should participate in other forms of scholarly activity, ~~must be demonstrated by~~ such as manuscript preparation, lectures, teaching activities, abstracts, ~~and active performance of~~ quality improvement projects, and research~~,~~ project preparation or ~~participation in~~project wrap-up. ~~clinical studies and reviews.~~ (~~Outcome~~Detail)

V. Evaluation

V.A. Fellow Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee. (Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. (Core)

V.A.1.a).(1) The program director may appoint additional members of the Clinical Competency Committee.

V.A.1.a).(1).(a) These additional members must be physician faculty members from the same program or

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610 other programs, or other health professionals
611 who have extensive contact and experience
612 with the program's fellows in patient care and
613 other health care settings. (Core)
614
615 **V.A.1.a).(1).(b)** **Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee.** (Core)
620
621 **V.A.1.b)** **There must be a written description of the responsibilities of the Clinical Competency Committee.** (Core)
623
624 **V.A.1.b).(1)** **The Clinical Competency Committee should:**
625
626 **V.A.1.b).(1).(a)** **review all fellow evaluations semi-annually;** (Core)
627
628 **V.A.1.b).(1).(b)** **prepare and ensure the reporting of Milestones evaluations of each fellow semi-annually to ACGME; and,** (Core)
631
632 **V.A.1.b).(1).(c)** **advise the program director regarding fellow progress, including promotion, remediation, and dismissal.** (Detail)
635
636 **V.A.2.** **Formative Evaluation**
637
638 **V.A.2.a)** **The faculty must evaluate fellow performance in a timely manner.** (Core)
640
641 **V.A.2.b)** **The program must:**
642
643 **V.A.2.b).(1)** **provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones;** (Core)
649
650 **V.A.2.b).(2)** **use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and,** (Detail)
652
653 **V.A.2.b).(3)** **provide each fellow with documented semiannual evaluation of performance with feedback.** (Core)
655
656 **V.A.2.c)** **The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.** (Detail)
659
660 **V.A.3.** **Summative Evaluation**

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661
662 **V.A.3.a)** **The specialty-specific Milestones must be used as one of the tools to ensure fellows are able to practice core professional activities without supervision upon completion of the program.** (Core)
666
667 **V.A.3.b)** **The program director must provide a summative evaluation for each fellow upon completion of the program.** (Core)
669
670 **This evaluation must:**
671
672 **V.A.3.b).(1)** **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;** (Detail)
676
677 **V.A.3.b).(2)** **document the fellow's performance during their education; and,** (Detail)
679
680 **V.A.3.b).(3)** **verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.** (Detail)
683
684 **V.B.** **Faculty Evaluation**
685
686 **V.B.1.** **At least annually, the program must evaluate faculty performance as it relates to the educational program.** (Core)
688
689 **V.B.2.** **These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.** (Detail)
692
693 **V.C.** **Program Evaluation and Improvement**
694
695 **V.C.1.** **The program director must appoint the Program Evaluation Committee (PEC).** **(Core)**
697
698 **V.C.1.a)** **The Program Evaluation Committee:**
699
700 **V.C.1.a).(1)** **must be composed of at least two program faculty members and should include at least one fellow;** **(Core)**
702
703 **V.C.1.a).(2)** **must have a written description of its responsibilities; and,** **(Core)**
705
706 **V.C.1.a).(3)** **should participate actively in:**
707
708 **V.C.1.a).(3).(a)** **planning, developing, implementing, and evaluating educational activities of the program;** **(Detail)**
711

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712 **V.C.1.a).(3).(b)** **reviewing and making recommendations for revision of competency-based curriculum goals and objectives;** **(Detail)**

716 **V.C.1.a).(3).(c)** **addressing areas of non-compliance with ACGME standards; and,** **(Detail)**

719 **V.C.1.a).(3).(d)** **reviewing the program annually using evaluations of faculty, fellows, and others, as specified below.** **(Detail)**

723 **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)

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

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

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

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

735 **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)**

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

743 **VI. The Learning and Working Environment**

745 ***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***

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- ***Commitment to the well-being of the students, residents/fellows, faculty members, and all members of the health care team***

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

VI.A.1. Patient Safety and Quality Improvement

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.

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

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

VI.A.1.a) Patient Safety

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

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

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

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

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

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

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

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

VI.A.1.a).(3).(a) **Residents, fellows, faculty members, and other clinical staff members must:**

VI.A.1.a).(3).(a).(i) **know their responsibilities in reporting patient safety events at the clinical site;** **(Core)**

VI.A.1.a).(3).(a).(ii) **know how to report patient safety events, including near misses, at the clinical site; and,** **(Core)**

VI.A.1.a).(3).(a).(iii) **be provided with summary information of their institution's patient safety reports.** **(Core)**

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)**

VI.A.1.a).(4) **Fellow Education and Experience in Disclosure of Adverse Events**

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.

VI.A.1.a).(4).(a) **All fellows must receive training in how to disclose adverse events to patients and families.** **(Core)**

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861 **VI.A.1.a).(4).(b)** **Fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated.** (Detail)
864
865 **VI.A.1.b)** **Quality Improvement**
866
867 **VI.A.1.b).(1)** **Education in Quality Improvement**
868
869 ***A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.***
873
874 **VI.A.1.b).(1).(a)** **Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities.** (Core)
877
878 **VI.A.1.b).(2)** **Quality Metrics**
879
880 ***Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.***
883
884 **VI.A.1.b).(2).(a)** **Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations.** (Core)
887
888 **VI.A.1.b).(3)** **Engagement in Quality Improvement Activities**
889
890 ***Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.***
893
894 **VI.A.1.b).(3).(a)** **Fellows must have the opportunity to participate in interprofessional quality improvement activities.** (Core)
897
898 **VI.A.1.b).(3).(a).(i)** **This should include activities aimed at reducing health care disparities.** (Detail)
900
901 **VI.A.2.** **Supervision and Accountability**
902
903 **VI.A.2.a)** ***Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.***
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Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

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)**

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)**

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)**

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.***

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)**

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

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

VI.A.2.c).(1) **Direct Supervision – the supervising physician is physically present with the fellow and patient.** **(Core)**

VI.A.2.c).(2) **Indirect Supervision:**

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962 **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)**
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968 **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)**
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975 **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)**
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979 **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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984 **VI.A.2.d).(1)** **The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones.** **(Core)**
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988 **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)**
989
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993 **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)**
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999 **VI.A.2.e)** **Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s).** **(Core)**
1000
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1003 **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)**
1004
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1008 **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)**
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1013 **VI.B. Professionalism**
1014
1015 **VI.B.1.** **Programs, in partnership with their Sponsoring Institutions, must**
1016 **educate fellows and faculty members concerning the professional**
1017 **responsibilities of physicians, including their obligation to be**
1018 **appropriately rested and fit to provide the care required by their**
1019 **patients.** (Core)
1020
1021 **VI.B.2.** **The learning objectives of the program must:**
1022
1023 **VI.B.2.a)** **be accomplished through an appropriate blend of supervised**
1024 **patient care responsibilities, clinical teaching, and didactic**
1025 **educational events;** (Core)
1026
1027 **VI.B.2.b)** **be accomplished without excessive reliance on fellows to**
1028 **fulfill non-physician obligations; and,** (Core)
1029
1030 **VI.B.2.c)** **ensure manageable patient care responsibilities.** (Core)
1031
1032 **VI.B.3.** **The program director, in partnership with the Sponsoring Institution,**
1033 **must provide a culture of professionalism that supports patient**
1034 **safety and personal responsibility.** (Core)
1035
1036 **VI.B.4.** **Fellows and faculty members must demonstrate an understanding**
1037 **of their personal role in the:**
1038
1039 **VI.B.4.a)** **provision of patient- and family-centered care;** (Outcome)
1040
1041 **VI.B.4.b)** **safety and welfare of patients entrusted to their care,**
1042 **including the ability to report unsafe conditions and adverse**
1043 **events;** (Outcome)
1044
1045 **VI.B.4.c)** **assurance of their fitness for work, including:** (Outcome)
1046
1047 **VI.B.4.c).(1)** **management of their time before, during, and after**
1048 **clinical assignments; and,** (Outcome)
1049
1050 **VI.B.4.c).(2)** **recognition of impairment, including from illness,**
1051 **fatigue, and substance use, in themselves, their peers,**
1052 **and other members of the health care team.** (Outcome)
1053
1054 **VI.B.4.d)** **commitment to lifelong learning;** (Outcome)
1055
1056 **VI.B.4.e)** **monitoring of their patient care performance improvement**
1057 **indicators; and,** (Outcome)
1058
1059 **VI.B.4.f)** **accurate reporting of clinical and educational work hours,**
1060 **patient outcomes, and clinical experience data.** (Outcome)
1061
1062 **VI.B.5.** **All fellows and faculty members must demonstrate responsiveness**
1063 **to patient needs that supersedes self-interest. This includes the**

1064 **recognition that under certain circumstances, the best interests of**
1065 **the patient may be served by transitioning that patient's care to**
1066 **another qualified and rested provider.** **(Outcome)**
1067
1068 **VI.B.6.** **Programs must provide a professional, respectful, and civil**
1069 **environment that is free from mistreatment, abuse, or coercion of**
1070 **students, residents/fellows, faculty, and staff. Programs, in**
1071 **partnership with their Sponsoring Institutions, should have a**
1072 **process for education of fellows and faculty regarding**
1073 **unprofessional behavior and a confidential process for reporting,**
1074 **investigating, and addressing such concerns.** **(Core)**
1075
1076 **VI.C.** **Well-Being**
1077
1078 ***In the current health care environment, fellows and faculty members are at***
1079 ***increased risk for burnout and depression. Psychological, emotional, and***
1080 ***physical well-being are critical in the development of the competent,***
1081 ***caring, and resilient physician. Self-care is an important component of***
1082 ***professionalism; it is also a skill that must be learned and nurtured in the***
1083 ***context of other aspects of fellowship training. Programs, in partnership***
1084 ***with their Sponsoring Institutions, have the same responsibility to address***
1085 ***well-being as they do to evaluate other aspects of fellow competence.***
1086
1087 **VI.C.1.** **This responsibility must include:**
1088
1089 **VI.C.1.a)** **efforts to enhance the meaning that each fellow finds in the**
1090 **experience of being a physician, including protecting time**
1091 **with patients, minimizing non-physician obligations,**
1092 **providing administrative support, promoting progressive**
1093 **autonomy and flexibility, and enhancing professional**
1094 **relationships;** **(Core)**
1095
1096 **VI.C.1.b)** **attention to scheduling, work intensity, and work**
1097 **compression that impacts fellow well-being;** **(Core)**
1098
1099 **VI.C.1.c)** **evaluating workplace safety data and addressing the safety of**
1100 **fellows and faculty members;** **(Core)**
1101
1102 **VI.C.1.d)** **policies and programs that encourage optimal fellow and**
1103 **faculty member well-being; and,** **(Core)**
1104
1105 **VI.C.1.d).(1)** **Fellows must be given the opportunity to attend**
1106 **medical, mental health, and dental care appointments,**
1107 **including those scheduled during their working hours.**
1108 **(Core)**
1109
1110 **VI.C.1.e)** **attention to fellow and faculty member burnout, depression,**
1111 **and substance abuse. The program, in partnership with its**
1112 **Sponsoring Institution, must educate faculty members and**
1113 **fellows in identification of the symptoms of burnout,**
1114 **depression, and substance abuse, including means to assist**

1115 **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)**

1121 **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)**

1128 **VI.C.1.e).(2)** **provide access to appropriate tools for self-screening; and, (Core)**

1131 **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)**

1136 **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)**

1145 **VI.D.** **Fatigue Mitigation**

1147 **VI.D.1.** **Programs must:**

1149 **VI.D.1.a)** **educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation; (Core)**

1152 **VI.D.1.b)** **educate all faculty members and fellows in alertness management and fatigue mitigation processes; and, (Core)**

1155 **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)**

1159 **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)**

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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)**

VI.E.1.a) ~~The program director must establish guidelines for the assignment of clinical responsibilities by the fellow, including clinic volume, on-call frequency and back up requirements, and the appropriate role in surgical procedures. (Core)~~

VI.E.2. Teamwork

VI.E.3. **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)~~

VI.E.3.a) ~~Each resident must have the opportunity to interact with other providers such as nurses, other specialists, social workers, and mid-level providers. (Core)~~

VI.E.4. Transitions of Care

VI.E.4.a) **Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.** **(Core)**

VI.E.4.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)**

VI.E.4.c) **Programs must ensure that fellows are competent in communicating with team members in the hand-over process.** **(Outcome)**

VI.E.4.d) **Programs and clinical sites must maintain and communicate schedules of attending physicians and fellows currently responsible for care.** **(Core)**

VI.E.4.e) **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**

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to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. **(Core)**

VI.F. Clinical Experience and Education

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

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

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

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)

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)

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)

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

VI.F.3.a) Clinical and educational work periods for fellows must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

VI.F.3.a).(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing

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effective transitions of care, and/or fellow education. **(Core)**

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

VI.F.4. **Clinical and Educational Work Hour Exceptions**

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

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

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

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

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

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

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

VI.F.4.c).(1) **In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*.** **(Core)**

VI.F.4.c).(2) **Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO.** **(Core)**

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)**

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1313 **VI.F.5.b)** **Time spent by fellows in internal and external moonlighting**
1314 **(as defined in the ACGME Glossary of Terms) must be**
1315 **counted toward the 80-hour maximum weekly limit.** (Core)
1316
1317 **VI.F.6.** **In-House Night Float**
1318
1319 **Night float must occur within the context of the 80-hour and one-**
1320 **day-off-in-seven requirements.** (Core)
1321
1322 **VI.F.7.** **Maximum In-House On-Call Frequency**
1323
1324 **Fellows must be scheduled for in-house call no more frequently than**
1325 **every third night (when averaged over a four-week period).** (Core)
1326
1327 **VI.F.8.** **At-Home Call**
1328
1329 **VI.F.8.a)** **Time spent on patient care activities by fellows on at-home**
1330 **call must count toward the 80-hour maximum weekly limit.**
1331 **The frequency of at-home call is not subject to the every-**
1332 **third-night limitation, but must satisfy the requirement for one**
1333 **day in seven free of clinical work and education, when**
1334 **averaged over four weeks.** (Core)
1335
1336 **VI.F.8.a).(1)** **At-home call must not be so frequent or taxing as to**
1337 **preclude rest or reasonable personal time for each**
1338 **fellow.** (Core)
1339
1340 **VI.F.8.b)** **Fellows are permitted to return to the hospital while on at-**
1341 **home call to provide direct care for new or established**
1342 **patients. These hours of inpatient patient care must be**
1343 **included in the 80-hour maximum weekly limit.** (Detail)
1344
1345 ***
1346
1347 ***Core Requirements:** Statements that define structure, resource, or process elements essential to every
1348 graduate medical educational program.
1349 **Detail Requirements:** Statements that describe a specific structure, resource, or process for achieving
1350 compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance
1351 with the Outcome Requirements may utilize alternative or innovative approaches to meet Core
1352 Requirements.
1353 **Outcome Requirements:** Statements that specify expected measurable or observable attributes
1354 (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical
1355 education.
1356
1357 **Osteopathic Recognition**
1358 For programs seeking Osteopathic Recognition for the entire program, or for a track within the program,
1359 the Osteopathic Recognition Requirements are also applicable.
1360 (http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recogniton_Requirement
1361 s.pdf)

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