ACGME Program Requirements for Graduate Medical Education in Emergency Medical Services (Subspecialty of Emergency Medicine)

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Proposed ACGME Program Requirements for Graduate Medical Education in Emergency Medical Services

Common Program Requirements (Fellowship) are in BOLD

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

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

Introduction

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

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

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

Int.B. **Definition of Subspecialty**

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Emergency medical services is a clinical specialty that includes the care of patients in all environments outside of traditional medical care facilities, including clinics, offices, and hospitals. It includes evaluation and treatment of acute injury and illness in all age groups, planning and prevention, monitoring, and team oversight.

Int.C. Length of Educational Program

The educational program in emergency medical services must be 12 months. (Core)*

I. Oversight

I.A. Sponsoring Institution

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

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

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

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

I.B. Participating Sites

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

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

I.B.1.a) The Sponsoring Institution must also sponsor an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency program in emergency medicine. (Core)

I.B.2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship

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90 **between the program and the participating site providing a required**
91 **assignment.** (Core)
92
93 **I.B.2.a) The PLA must:**
94
95 **I.B.2.a).(1) be renewed at least every 10 years; and,** (Core)
96
97 **I.B.2.a).(2) be approved by the designated institutional official**
98 **(DIO).** (Core)
99
100 **I.B.3. The program must monitor the clinical learning and working**
101 **environment at all participating sites.** (Core)
102
103 **I.B.3.a) At each participating site there must be one faculty member,**
104 **designated by the program director, who is accountable for**
105 **fellow education for that site, in collaboration with the**
106 **program director.** (Core)
107

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

Suggested elements to be considered in PLAs will be found in the ACGME Program Director's Guide to the Common Program Requirements. These include:
- **Identifying the faculty members who will assume educational and supervisory responsibility for fellows**
- **Specifying the responsibilities for teaching, supervision, and formal evaluation of fellows**
- **Specifying the duration and content of the educational experience**
- **Stating the policies and procedures that will govern fellow education during the assignment**

108
109 **I.B.4. The program director must submit any additions or deletions of**
110 **participating sites routinely providing an educational experience,**
111 **required for all fellows, of one month full time equivalent (FTE) or**
112 **more through the ACGME's Accreditation Data System (ADS).** (Core)
113
114 I.B.5. The program should be based at the primary clinical site. (Core)
115
116 I.B.6. Required rotations to participating sites that are geographically distant
117 from the sponsoring institution should offer special resources unavailable
118 locally that significantly augment the overall educational experience of the
119 program. (Detail)†

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I.B.7. The number and location of participating sites must not preclude the satisfactory participation by all residents in conferences and other educational experiences. (Core)

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

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

I.D. Resources

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

I.D.1.a) Adult and pediatric medical transports in all types of settings outside of traditional medical care settings must be available. (Core)

I.D.1.b) The primary clinical site must provide:

I.D.1.b).(1) an emergency service that has access to adult and pediatric patients; (Core)

I.D.1.b).(2) access to adult and pediatric inpatient facilities; (Core)

I.D.1.b).(3) disaster planning and response programs; and, (Core)

I.D.1.b).(4) two-way communications between the primary clinical site and surrounding medical transportation services for provision of direct medical oversight. (Core)

I.D.1.c) The primary clinical site should organize and ensure provision of transportation for fellows to provide pre-hospital patient care. (Core)

I.D.1.d) There should be an air medical evacuation and inter-facility transportation service accessible from the primary clinical site. (Core)

I.D.1.e) There must be a patient population that includes patients of all ages and genders, with a wide variety of clinical problems, and that is adequate in number and variety to meet the educational needs of the program. (Core)

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165 I.D.1.f) Fellows must be provided with prompt, reliable systems for
166 communication and interactions with supervisory physicians. (Core)
167
168 **I.D.2. The program, in partnership with its Sponsoring Institution, must**
169 **ensure healthy and safe learning and working environments that**
170 **promote fellow well-being and provide for: (Core)**
171
172 **I.D.2.a) access to food while on duty; (Core)**
173
174 **I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available**
175 **and accessible for fellows with proximity appropriate for safe**
176 **patient care; (Core)**
177

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that fellows function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while fellows are working. Fellows should have access to refrigeration where food may be stored. Food should be available when fellows are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued fellow.

178
179 **I.D.2.c) clean and private facilities for lactation that have refrigeration**
180 **capabilities, with proximity appropriate for safe patient care;**
181 **(Core)**
182

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

183
184 **I.D.2.d) security and safety measures appropriate to the participating**
185 **site; and, (Core)**
186
187 **I.D.2.e) accommodations for fellows with disabilities consistent with**
188 **the Sponsoring Institution’s policy. (Core)**
189
190 **I.D.3. Fellows must have ready access to subspecialty-specific and other**
191 **appropriate reference material in print or electronic format. This**
192 **must include access to electronic medical literature databases with**
193 **full text capabilities. (Core)**
194
195 **I.D.4. The program’s educational and clinical resources must be adequate**
196 **to support the number of fellows appointed to the program. (Core)**
197

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

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

Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that fellows' education is not compromised by the presence of other providers and learners, and that fellows' education does not compromise core residents' education.

II. Personnel

II.A. Program Director

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

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

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

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

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

II.A.2.a) ~~The sponsoring institution and participating sites must provide at least 25 percent salary support or equivalent protected time for program directors. (Detail)~~

II.A.2.b) The program director must be provided minimum protected time for the administration of the program based on program size according to the following: (Core)

Program Size	% FTE Required
0-3 fellows	20%
4-6 fellows	25%
7-9 fellows	30%
>10 fellows	35%

234
235 **II.A.3.** **Qualifications of the program director:**
236
237 **II.A.3.a)** **must include subspecialty expertise and qualifications**
238 **acceptable to the Review Committee; (Core)**
239
240 II.A.3.a).(1) This must include at least three years' experience as a
241 core physician faculty member in an ACGME-accredited
242 emergency medicine program or emergency medical
243 services program; (Core)(Detail)
244
245 **II.A.3.b)** **must include current certification in the subspecialty for**
246 **which they are the program director by the American Board**
247 **of** Emergency Medicine **or by the American Osteopathic Board**
248 **of** Emergency Medicine**, or subspecialty qualifications that are**
249 **acceptable to the Review Committee; (Core)**
250
251 II.A.3.c) continuation in his or her position for a length of time adequate to
252 maintain continuity of leadership and program stability; (Detail)
253
254 II.A.3.d) must include current clinical activity in the practice of emergency
255 medical services; (Core)
256
257 II.A.3.e) must demonstrate an average of 10 hours per week of his or her
258 professional effort dedicated to the fellowship, with sufficient time
259 for administration of the program; and, (Core)
260
261 II.A.3.f) should include demonstrated participation in academic societies
262 and educational programs designed to enhance his or her
263 educational and administrative skills. (Core)(Detail)
264
265 **II.A.4.** **Program Director Responsibilities**
266
267 **The program director must have responsibility, authority, and**
268 **accountability for: administration and operations; teaching and**
269 **scholarly activity; fellow recruitment and selection, evaluation, and**
270 **promotion of fellows, and disciplinary action; supervision of fellows;**
271 **and fellow education in the context of patient care. (Core)**
272
273 **II.A.4.a)** **The program director must:**
274
275 **II.A.4.a).(1)** **be a role model of professionalism; (Core)**
276

Background and Intent: The program director, as the leader of the program, must serve as a role model to fellows in addition to fulfilling the technical aspects of the role. As

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

277
278 **II.A.4.a).(2)** **design and conduct the program in a fashion**
279 **consistent with the needs of the community, the**
280 **mission(s) of the Sponsoring Institution, and the**
281 **mission(s) of the program;** (Core)
282

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

283
284 **II.A.4.a).(3)** **administer and maintain a learning environment**
285 **conducive to educating the fellows in each of the**
286 **ACGME Competency domains;** (Core)
287

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

288
289 **II.A.4.a).(4)** **develop and oversee a process to evaluate candidates**
290 **prior to approval as program faculty members for**
291 **participation in the fellowship program education and**
292 **at least annually thereafter, as outlined in V.B.;** (Core)
293
294 **II.A.4.a).(5)** **have the authority to approve program faculty**
295 **members for participation in the fellowship program**
296 **education at all sites;** (Core)
297
298 **II.A.4.a).(6)** **have the authority to remove program faculty**
299 **members from participation in the fellowship program**
300 **education at all sites;** (Core)
301
302 **II.A.4.a).(7)** **have the authority to remove fellows from supervising**
303 **interactions and/or learning environments that do not**
304 **meet the standards of the program;** (Core)
305

Background and Intent: The program director has the responsibility to ensure that all who educate fellows effectively role model the Core Competencies. Working with a fellow is a privilege that is earned through effective teaching and professional role

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modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.

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

306
307 **II.A.4.a).(8)** **submit accurate and complete information required**
308 **and requested by the DIO, GMEC, and ACGME;** (Core)
309
310 **II.A.4.a).(9)** **provide applicants who are offered an interview with**
311 **information related to the applicant's eligibility for the**
312 **relevant subspecialty board examination(s);** (Core)
313
314 **II.A.4.a).(10)** **provide a learning and working environment in which**
315 **fellows have the opportunity to raise concerns and**
316 **provide feedback in a confidential manner as**
317 **appropriate, without fear of intimidation or retaliation;**
318 (Core)
319
320 **II.A.4.a).(11)** **ensure the program's compliance with the Sponsoring**
321 **Institution's policies and procedures related to**
322 **grievances and due process;** (Core)
323
324 **II.A.4.a).(12)** **ensure the program's compliance with the Sponsoring**
325 **Institution's policies and procedures for due process**
326 **when action is taken to suspend or dismiss, not to**
327 **promote, or not to renew the appointment of a fellow;**
328 (Core)
329

Background and Intent: A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures, and will ensure they are followed by the program's leadership, faculty members, support personnel, and fellows.

330
331 **II.A.4.a).(13)** **ensure the program's compliance with the Sponsoring**
332 **Institution's policies and procedures on employment**
333 **and non-discrimination;** (Core)
334
335 **II.A.4.a).(13).(a)** **Fellows must not be required to sign a non-**
336 **competition guarantee or restrictive covenant.**
337 (Core)
338
339 **II.A.4.a).(14)** **document verification of program completion for all**
340 **graduating fellows within 30 days;** (Core)
341
342 **II.A.4.a).(15)** **provide verification of an individual fellow's**
343 **completion upon the fellow's request, within 30 days;**
344 **and,** (Core)
345

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

346
347 **II.A.4.a).(16)** **obtain review and approval of the Sponsoring**
348 **Institution's DIO before submitting information or**
349 **requests to the ACGME, as required in the Institutional**
350 **Requirements and outlined in the ACGME Program**
351 **Director's Guide to the Common Program**
352 **Requirements. (Core)**
353
354 **II.B. Faculty**
355
356 ***Faculty members are a foundational element of graduate medical education***
357 ***– faculty members teach fellows how to care for patients. Faculty members***
358 ***provide an important bridge allowing fellows to grow and become practice***
359 ***ready, ensuring that patients receive the highest quality of care. They are***
360 ***role models for future generations of physicians by demonstrating***
361 ***compassion, commitment to excellence in teaching and patient care,***
362 ***professionalism, and a dedication to lifelong learning. Faculty members***
363 ***experience the pride and joy of fostering the growth and development of***
364 ***future colleagues. The care they provide is enhanced by the opportunity to***
365 ***teach. By employing a scholarly approach to patient care, faculty members,***
366 ***through the graduate medical education system, improve the health of the***
367 ***individual and the population.***
368
369 ***Faculty members ensure that patients receive the level of care expected***
370 ***from a specialist in the field. They recognize and respond to the needs of***
371 ***the patients, fellows, community, and institution. Faculty members provide***
372 ***appropriate levels of supervision to promote patient safety. Faculty***
373 ***members create an effective learning environment by acting in a***
374 ***professional manner and attending to the well-being of the fellows and***
375 ***themselves.***
376

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

377
378 **II.B.1.** **For each participating site, there must be a sufficient number of**
379 **faculty members with competence to instruct and supervise all**
380 **fellows at that location. (Core)**
381
382 II.B.1.a) There must be at least two subspecialty physician faculty
383 members, in addition to the program director, who devote a
384 minimum of five hours per week of their time to supervision of the
385 fellows. (Core)
386

387 II.B.1.b) Consultants and/or program faculty members should be available
388 for consultation and academic lectures. (Detail)
389
390 II.B.1.b).(1) Consultants and/or program faculty members should
391 include those with special expertise in air medical services,
392 biostatistics, cardiology, critical care, disaster and mass
393 casualty incident management, epidemiology, forensics,
394 hazardous materials and mass exposure to toxins, mass
395 gatherings, neurology, pediatrics, pharmacology,
396 psychiatry, public health, pulmonary medicine,
397 resuscitation, toxicology, and trauma surgery. (Detail)
398
399 **II.B.2. Faculty members must:**
400
401 **II.B.2.a) be role models of professionalism; (Core)**
402
403 **II.B.2.b) demonstrate commitment to the delivery of safe, quality,**
404 **cost-effective, patient-centered care; (Core)**
405

Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.

406
407 **II.B.2.c) demonstrate a strong interest in the education of fellows; (Core)**
408
409 **II.B.2.d) devote sufficient time to the educational program to fulfill**
410 **their supervisory and teaching responsibilities; (Core)**
411
412 **II.B.2.e) administer and maintain an educational environment**
413 **conducive to educating fellows; (Core)**
414
415 **II.B.2.f) regularly participate in organized clinical discussions,**
416 **rounds, journal clubs, and conferences; and, (Core)**
417
418 **II.B.2.g) pursue faculty development designed to enhance their skills**
419 **at least annually. (Core)**
420

Background and Intent: Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the fellowship program faculty in the aggregate.

421
422 II.B.2.g).(1) Faculty members should participate in faculty development
423 programs designed to enhance the effectiveness of their
424 teaching. (Detail)
425

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426 **II.B.3. Faculty Qualifications**
427
428 **II.B.3.a) Faculty members must have appropriate qualifications in**
429 **their field and hold appropriate institutional appointments.**
430 **(Core)**
431
432 II.B.3.a).(1) Program faculty members must have appropriate faculty
433 appointments at the medical school. (Core)
434
435 **II.B.3.b) Subspecialty physician faculty members must:**
436
437 **II.B.3.b).(1) have current certification in the subspecialty by the**
438 **American Board of** Emergency Medicine **or the**
439 **American Osteopathic Board of** Emergency Medicine**, or**
440 **possess qualifications judged acceptable to the**
441 **Review Committee. (Core)**
442
443 **II.B.3.c) Any non-physician faculty members who participate in**
444 **fellowship program education must be approved by the**
445 **program director. (Core)**
446

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

447
448 **II.B.3.d) Any other specialty physician faculty members must have**
449 **current certification in their specialty by the appropriate**
450 **American Board of Medical Specialties (ABMS) member**
451 **board or American Osteopathic Association (AOA) certifying**
452 **board, or possess qualifications judged acceptable to the**
453 **Review Committee. (Core)**
454
455 **II.B.4. Core Faculty**
456
457 **Core faculty members must have a significant role in the education**
458 **and supervision of fellows and must devote a significant portion of**
459 **their entire effort to fellow education and/or administration, and**
460 **must, as a component of their activities, teach, evaluate, and provide**
461 **formative feedback to fellows. (Core)**
462

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

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

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

II.B.4.c) In addition to the program director there must be at least two core physician faculty members with EMS experience whose practice makes them available for consultation by fellows. (Core)~~(Detail)~~

II.C. Program Coordinator

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

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

II.C.2.a) At a minimum, there must be at least one 0.2 FTE program coordinator dedicated solely to the fellowship program administration. (Core)

Background and Intent: Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison with learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME. The program coordinator is a member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management. Program coordinators are expected to develop unique knowledge of the ACGME and Program Requirements, policies, and procedures. Program coordinators assist the program director in accreditation efforts, educational programming, and support of fellows. Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer fellows may not require a full-time coordinator; one coordinator may support more than one program.

II.D. Other Program Personnel

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

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

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program. These personnel may support more than one program in more than one discipline.

III. Fellow Appointments

III.A. Eligibility Criteria

III.A.1. Eligibility Requirements – Fellowship Programs

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

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

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

III.A.1.b) Prior to entry into the program fellows must have successfully completed a residency program that satisfies III.A.1., excluding transitional year programs. (Core)

III.A.1.c) Fellow Eligibility Exception

The Review Committee for Emergency Medicine **will allow the following exception to the fellowship eligibility requirements:**

Specialty Background and Intent: When exercising the Eligibility Exception for an exceptionally qualified candidate who is seeking board certification, programs must be aware that completing an ACGME-accredited fellowship program may not by itself be sufficient to meet the eligibility requirements for subspecialty certification. Programs must contact the applicable certifying board directly to determine an applicant's eligibility for certification.

III.A.1.c).(1) An ACGME-accredited fellowship program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1., but who does meet all of the following additional qualifications and conditions: (Core)

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532 **III.A.1.c).(1).(a)** **evaluation by the program director and**
533 **fellowship selection committee of the**
534 **applicant's suitability to enter the program,**
535 **based on prior training and review of the**
536 **summative evaluations of training in the core**
537 **specialty; and, (Core)**
538
539 **III.A.1.c).(1).(b)** **review and approval of the applicant's**
540 **exceptional qualifications by the GMEC; and,**
541 **(Core)**
542
543 **III.A.1.c).(1).(c)** **verification of Educational Commission for**
544 **Foreign Medical Graduates (ECFMG)**
545 **certification. (Core)**
546
547 **III.A.1.c).(2)** **Applicants accepted through this exception must have**
548 **an evaluation of their performance by the Clinical**
549 **Competency Committee within 12 weeks of**
550 **matriculation. (Core)**
551

Background and Intent: An exceptionally qualified international graduate applicant has (1) completed a residency program in the core specialty outside the continental United States that was not accredited by the ACGME, AOA, ACGME-I, RCPSC or CFPC, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; and/or (c) demonstrated leadership during or after residency. Applicants being considered for these positions must be informed of the fact that their training may not lead to certification by ABMS member boards or AOA certifying boards. **In recognition of the diversity of medical education and training around the world, this early evaluation of clinical competence required for these applicants ensures they can provide quality and safe patient care. Any gaps in competence should be addressed as per policies for fellows already established by the program in partnership with the Sponsoring Institution.**

552
553 **III.B.** **The program director must not appoint more fellows than approved by the**
554 **Review Committee. (Core)**
555
556 **III.B.1.** **All complement increases must be approved by the Review**
557 **Committee. (Core)**
558
559 **III.C.** **Fellow Transfers**
560
561 **The program must obtain verification of previous educational experiences**
562 **and a summative competency-based performance evaluation prior to**
563 **acceptance of a transferring fellow, and Milestones evaluations upon**
564 **matriculation. (Core)**
565
566 **IV. Educational Program**

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

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

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

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

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

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

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

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

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

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

Background and Intent: Patient care-related educational activities, such as morbidity and mortality conferences, tumor boards, surgical planning conferences, case discussions, etc., allow fellows to gain medical knowledge directly applicable to the

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patients they serve. Programs should define those educational activities in which fellows are expected to participate and for which time is protected. Further specification can be found in IV.C.

609
610 **IV.A.5.** **advancement of fellows' knowledge of ethical principles**
611 **foundational to medical professionalism.** **(Core)**
612
613 **IV.B. ACGME Competencies**
614

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

615
616 **IV.B.1.** **The program must integrate the following ACGME Competencies**
617 **into the curriculum:** **(Core)**
618
619 **IV.B.1.a)** **Professionalism**
620
621 **Fellows must demonstrate a commitment to professionalism**
622 **and an adherence to ethical principles.** **(Core)**
623
624 **IV.B.1.b)** **Patient Care and Procedural Skills**
625

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

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

626
627 **IV.B.1.b).(1)** **Fellows must be able to provide patient care that is**
628 **compassionate, appropriate, and effective for the**
629 **treatment of health problems and the promotion of**
630 **health.** **(Core)**
631
632 IV.B.1.b).(1).(a) Fellows must demonstrate competence in the
633 practice of patient evaluation and treatment of
634 patients of all ages and genders requiring
635 emergency medical services by: (Core)
636

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637 IV.B.1.b).(1).(a).(i) gathering accurate, essential information in
638 a timely manner; (Core)
639
640 IV.B.1.b).(1).(a).(ii) evaluating and comprehensively treating
641 acutely-ill and injured patients in the pre-
642 hospital setting; (Core)
643
644 IV.B.1.b).(1).(a).(iii) prioritizing and stabilizing multiple patients
645 in the pre-hospital setting while performing
646 other responsibilities simultaneously; (Core)
647
648 IV.B.1.b).(1).(a).(iv) properly sequencing critical actions for
649 patient care; (Core)
650
651 IV.B.1.b).(1).(a).(v) integrating information obtained from patient
652 history, physical examination, physiologic
653 recordings, and test results to arrive at an
654 accurate assessment and treatment plan;
655 (Core)
656
657 IV.B.1.b).(1).(a).(vi) integrating relevant biological, psychosocial,
658 social, economic, ethnic, and familial factors
659 into the evaluation and treatment of their
660 patients; and, (Core)
661
662 IV.B.1.b).(1).(a).(vii) planning and implementing therapeutic
663 treatment, including pharmaceutical,
664 medical device, behavioral, and surgical
665 therapies. (Core)
666
667 **IV.B.1.b).(2) Fellows must be able to perform all medical,**
668 **diagnostic, and surgical procedures considered**
669 **essential for the area of practice. (Core)**
670
671 IV.B.1.b).(2).(a) Fellows must demonstrate competence in the
672 practice of technical skills of patients of all ages
673 and genders requiring emergency medical services
674 by: (Core)
675
676 IV.B.1.b).(2).(a).(i) performing physical examinations relevant
677 to the practice of emergency medical
678 services (Core)
679
680 IV.B.1.b).(2).(a).(ii) performing the following key index
681 procedures: (Core)
682
683 IV.B.1.b).(2).(a).(ii).(a) participation in a mass
684 casualty/disaster triage at an actual
685 event or drill; (Core)
686

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687 IV.B.1.b).(2).(a).(ii).(b) participation in a sentinel event
688 investigation; (Core)
689
690 IV.B.1.b).(2).(a).(ii).(c) conduction of a quality management
691 audit; (Core)
692
693 IV.B.1.b).(2).(a).(ii).(d) development of a mass gathering
694 medical plan and participation in its
695 implementation; (Core)
696
697 IV.B.1.b).(2).(a).(ii).(e) emergency medical services
698 protocol development or revision;
699 (Core)
700
701 IV.B.1.b).(2).(a).(ii).(f) immobilization of the spine; (Core)
702
703 IV.B.1.b).(2).(a).(ii).(g) immobilization of an injured
704 extremity; (Core)
705
706 IV.B.1.b).(2).(a).(ii).(h) management of a cardiac arrest in
707 the pre-hospital setting; (Core)
708
709 IV.B.1.b).(2).(a).(ii).(i) management of a compromised
710 airway in the pre-hospital setting;
711 and, (Core)
712
713 IV.B.1.b).(2).(a).(ii).(j) provision of direct medical oversight
714 on-scene, or by radio or phone. (Core)
715
716 **IV.B.1.c)** **Medical Knowledge**
717
718 **Fellows must demonstrate knowledge of established and**
719 **evolving biomedical, clinical, epidemiological and social-**
720 **behavioral sciences, as well as the application of this**
721 **knowledge to patient care. (Core)**
722
723 IV.B.1.c).(1) Fellows must demonstrate competence in their knowledge
724 of the following:
725
726 IV.B.1.c).(1).(a) clinical manifestations and management of acutely-
727 ill and injured patients in the pre-hospital setting;
728 (Core)
729
730 IV.B.1.c).(1).(b) disaster planning and response; (Core)
731
732 IV.B.1.c).(1).(c) evidence-based decision making; (Core)
733
734 IV.B.1.c).(1).(d) procedures and techniques necessary for the
735 stabilization and treatment of patients in the pre-
736 hospital setting; (Core)
737

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738 IV.B.1.c).(1).(e) provision of medical care in mass gatherings; (Core)
739
740 IV.B.1.c).(1).(f) public safety answering points, dispatch centers,
741 emergency communication centers' operation, and
742 medical oversight; (Core)
743
744 IV.B.1.c).(1).(g) experimental design and statistical analysis of data
745 as related to emergency medical services clinical
746 outcomes and epidemiologic research; (Core)
747
748 IV.B.1.c).(1).(h) models, function, management, and financing of
749 emergency medical services systems; (Core)
750
751 IV.B.1.c).(1).(i) principles of quality improvement and patient
752 safety; and, (Core)
753
754 IV.B.1.c).(1).(j) principles of epidemiology and research
755 methodologies in emergency medical services. (Core)
756
757 **IV.B.1.d) Practice-based Learning and Improvement**
758
759 **Fellows must demonstrate the ability to investigate and**
760 **evaluate their care of patients, to appraise and assimilate**
761 **scientific evidence, and to continuously improve patient care**
762 **based on constant self-evaluation and lifelong learning. (Core)**
763

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

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

764
765 **IV.B.1.f) Interpersonal and Communication Skills**
766
767 **Fellows must demonstrate interpersonal and communication**
768 **skills that result in the effective exchange of information and**
769 **collaboration with patients, their families, and health**
770 **professionals. (Core)**
771
772 **IV.B.1.g) Systems-based Practice**
773
774 **Fellows must demonstrate an awareness of and**
775 **responsiveness to the larger context and system of health**
776 **care, including the social determinants of health, as well as**
777 **the ability to call effectively on other resources to provide**
778 **optimal health care. (Core)**
779
780 **IV.C. Curriculum Organization and Fellow Experiences**

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

IV.C.1.a) Clinical experiences should be structured to facilitate learning in a manner that allows the fellows to function as part of an effective interprofessional team that works together towards the shared goals of patient safety and quality improvement. (Detail)

IV.C.1.b) The program director is responsible for determining the duration of the clinical experiences for fellows on all rotations. (Core)

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

IV.C.3. Didactic Experiences

IV.C.3.a) The core curriculum must include a didactic program based upon the core knowledge content of emergency medical services and consistent with the required outcomes specified for medical knowledge. (Core)

IV.C.3.b) There must be regularly scheduled didactic sessions; (Core)

IV.C.3.b).(1) Didactic sessions must include presentations based on the defined curriculum, administrative seminars, journal review, morbidity and mortality conferences, and research seminars, and should include joint conferences co-sponsored with other disciplines. (Core)

IV.C.3.b).(1).(a) Educational methods should include problem-based learning, evidence-based learning, laboratory-based instruction, and computer-based instruction. (Detail)

IV.C.3.b).(1).(b) The program must provide an educational justification if alternative methods of education are used. (Detail)

IV.C.3.b).(1).(c) All planned didactic experiences must have an evaluative component to measure fellow participation and educational effectiveness, including faculty member-fellow interaction. (Core) ~~(Outcome)~~

IV.C.3.c) The curriculum must provide an average of at least three hours per week of planned didactic experiences developed by the program faculty members. (Core)

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IV.C.3.c).(1) Fellows must participate, on average, in at least 70 percent of the planned didactic experiences offered. (Core)

IV.C.3.c).(2) Fellows must participate in planning and conducting didactic experiences, and delivery of didactic experiences to the core emergency medicine program. (Core)~~(Detail)~~

IV.C.3.c).(3) All planned didactic experiences must be supervised by faculty members. (Core)

IV.C.3.c).(3).(a) Each core physician faculty member must attend, on average, at least 25 percent of planned didactic experiences. (Core)~~(Detail)~~

IV.C.3.c).(3).(b) Faculty members must present more than 50 percent of planned didactic experiences. (Core)~~(Detail)~~

IV.C.4. Fellow Experiences

Fellows' experiences must include the following:

IV.C.4.a) 12 months as the primary or consulting physician responsible for providing direct patient evaluation and management in the pre-hospital setting, as well as supervision of care provided by all allied health providers in the pre-hospital setting; (Core)

IV.C.4.b) experience with regional and state offices of emergency medical services and other regulatory bodies that affect the care of patients in the pre-hospital setting; (Core)

IV.C.4.c) ensure exposure and education in medical direction of air medical transports or an experience that would include supervision of air medical crews during medical transports; (Core)

IV.C.4.d) participating in administrative components of an emergency medical services system to determine functioning, designs, and processes to ensure quality of patient care in the pre-hospital setting; (Core)

IV.C.4.e) providing exposure to clinical services in a variety of emergency medical services systems, including third-service, and fire-based, governmental, and for-profit services; (Core)

IV.C.4.f) providing direct medical oversight of patient care by emergency medical services personnel, including: (Core)

IV.C.4.f).(1) experience in an emergency communications center and a public safety answering point utilizing emergency medical dispatching guidelines. (Core)

IV.C.4.g) providing evaluations and management of both adult and pediatric

883 aged acutely-ill and injured patients in the pre-hospital setting; (Core)
884
885 IV.C.4.h) a unified educational experience. (Detail)
886
887 **IV.D. Scholarship**
888
889 ***Medicine is both an art and a science. The physician is a humanistic***
890 ***scientist who cares for patients. This requires the ability to think critically,***
891 ***evaluate the literature, appropriately assimilate new knowledge, and***
892 ***practice lifelong learning. The program and faculty must create an***
893 ***environment that fosters the acquisition of such skills through fellow***
894 ***participation in scholarly activities as defined in the subspecialty-specific***
895 ***Program Requirements. Scholarly activities may include discovery,***
896 ***integration, application, and teaching.***
897
898 ***The ACGME recognizes the diversity of fellowships and anticipates that***
899 ***programs prepare physicians for a variety of roles, including clinicians,***
900 ***scientists, and educators. It is expected that the program's scholarship will***
901 ***reflect its mission(s) and aims, and the needs of the community it serves.***
902 ***For example, some programs may concentrate their scholarly activity on***
903 ***quality improvement, population health, and/or teaching, while other***
904 ***programs might choose to utilize more classic forms of biomedical***
905 ***research as the focus for scholarship.***
906
907 **IV.D.1. Program Responsibilities**
908
909 **IV.D.1.a) The program must demonstrate evidence of scholarly**
910 **activities, consistent with its mission(s) and aims.** **(Core)**
911
912 **IV.D.1.b) The program in partnership with its Sponsoring Institution,**
913 **must allocate adequate resources to facilitate fellow and**
914 **faculty involvement in scholarly activities.** **(Core)**
915
916 **IV.D.2. Faculty Scholarly Activity**
917
918 **IV.D.2.a) Among their scholarly activity, programs must demonstrate**
919 **accomplishments in at least three of the following domains:**
920 **(Core)**
921
922 - **Research in basic science, education, translational**
923 **science, patient care, or population health**
924 - **Peer-reviewed grants**
925 - **Quality improvement and/or patient safety initiatives**
926 - **Systematic reviews, meta-analyses, review articles,**
927 **chapters in medical textbooks, or case reports**
928 - **Creation of curricula, evaluation tools, didactic**
929 **educational activities, or electronic educational**
930 **materials**
931 - **Contribution to professional committees, educational**
932 **organizations, or editorial boards**

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933 • **Innovations in education**
934
935 **IV.D.2.b)** **The program must demonstrate dissemination of scholarly**
936 **activity within and external to the program by the following**
937 **methods:**
938

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

939
940 **IV.D.2.b).(1)** **faculty participation in grand rounds, posters,**
941 **workshops, quality improvement presentations,**
942 **podium presentations, grant leadership, non-peer-**
943 **reviewed print/electronic resources, articles or**
944 **publications, book chapters, textbooks, webinars,**
945 **service on professional committees, or serving as a**
946 **journal reviewer, journal editorial board member, or**
947 **editor; (Outcome)**
948
949 **IV.D.2.b).(2)** **peer-reviewed publication. (Outcome)**
950
951 IV.D.2.b).(2).(a) All core faculty members must demonstrate
952 significant contributions to the subspecialty of
953 emergency medical services through scholarly
954 activity. (Core)
955
956 IV.D.2.b).(2).(b) At minimum, each individual core physician faculty
957 member must demonstrate at least one piece of
958 scholarly activity per year, averaged over the past
959 five years. (Core)
960
961 IV.D.2.b).(2).(b).(i) At minimum, this must include one scientific
962 peer-reviewed publication for every two core
963 physician faculty members per year,
964 averaged over the previous five-year period.
965 (Core) ~~(Detail)~~
966
967 **IV.D.3.** **Fellow Scholarly Activity**
968
969 IV.D.3.a) The curriculum must advance fellows' knowledge of the basic
970 principles of research, including how research is conducted,
971 evaluated, explained to patients, and applied to patient care. (Core)
972
973 IV.D.3.b) Fellows must participate in scholarly activity that includes at least
974 one of the following:

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975
976 IV.D.3.b).(1) peer-reviewed funding and research; (Outcome)
977
978 IV.D.3.b).(2) publication of original research or review articles; or,
979 (Outcome)
980
981 IV.D.3.b).(3) presentations at local, regional, or national professional
982 and scientific society meetings. (Outcome)
983
984 **IV.E.** ***Fellowship programs may assign fellows to engage in the independent***
985 ***practice of their core specialty during their fellowship program.***
986
987 [The Review Committee's proposal to allow the independent practice option is
988 part of the focused revision and is subject to public comment.]
989
990 **IV.E.1.** **If programs permit their fellows to utilize the independent practice**
991 **option, it must not exceed 20 percent of their time per week or 10**
992 **weeks of an academic year.** (Core)
993

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

994
995 IV.E.2. Fellows should maintain their primary Board skills during their fellowships.
996 (Core)~~(Detail)~~ [Moved from IV.C.5.]
997
998 IV.E.2.a) ~~Fellows must not provide more than 12 hours per week of clinical~~
999 ~~practice unrelated to emergency medical services averaged over~~
1000 ~~four weeks. (Detail)~~ [Moved from IV.C.5.a)]
1001

Specialty Specific Background and Intent: The Review Committee for Emergency Medicine considers the requirements above to be exclusive of moonlighting. Additional time spent by the fellows in the engagement of independent practice of their core specialty beyond the maximum stated in the requirements will be considered moonlighting, and will be counted toward the 80-hour maximum clinical time per week.

1002
1003 **V. Evaluation**
1004
1005 **V.A. Fellow Evaluation**
1006
1007 **V.A.1. Feedback and Evaluation**
1008

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower fellows to provide much of that feedback themselves in a spirit of continuous learning and self-

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reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

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

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

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

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

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

1009
1010 **V.A.1.a)** **Faculty members must directly observe, evaluate, and**
1011 **frequently provide feedback on fellow performance during**
1012 **each rotation or similar educational assignment.** (Core)
1013
1014 V.A.1.a).(1) Faculty members must review evaluations with each fellow
1015 at least every six months. (Core)
1016

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Fellows require feedback from faculty members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for fellows who have deficiencies that may result in a poor final rotation evaluation.

1017
1018 **V.A.1.b)** **Evaluation must be documented at the completion of the**
1019 **assignment.** (Core)
1020
1021 **V.A.1.b).(1)** **For block rotations of greater than three months in**
1022 **duration, evaluation must be documented at least**
1023 **every three months.** (Core)
1024
1025 **V.A.1.b).(2)** **Longitudinal experiences such as continuity clinic in**
1026 **the context of other clinical responsibilities must be**
1027 **evaluated at least every three months and at**
1028 **completion.** (Core)

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1029
1030 **V.A.1.c)** **The program must provide an objective performance evaluation based on the Competencies and the subspecialty-specific Milestones, and must:** **(Core)**
1031
1032
1033
1034 **V.A.1.c).(1)** **use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and,** **(Core)**
1035
1036
1037
1038 **V.A.1.c).(2)** **provide that information to the Clinical Competency Committee for its synthesis of progressive fellow performance and improvement toward unsupervised practice.** **(Core)**
1039
1040
1041
1042

Background and Intent: The trajectory to autonomous practice in a subspecialty is documented by the subspecialty-specific Milestones evaluation during fellowship. These Milestones detail the progress of a fellow in attaining skill in each competency domain. It is expected that the most growth in fellowship education occurs in patient care and medical knowledge, while the other four domains of competency must be ensured in the context of the subspecialty. They are developed by a subspecialty group and allow evaluation based on observable behaviors. The Milestones are considered formative and should be used to identify learning needs. This may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific fellow.

1043
1044 **V.A.1.d)** **The program director or their designee, with input from the Clinical Competency Committee, must:**
1045
1046
1047 **V.A.1.d).(1)** **meet with and review with each fellow their documented semi-annual evaluation of performance, including progress along the subspecialty-specific Milestones.** **(Core)**
1048
1049
1050
1051
1052 **V.A.1.d).(2)** **assist fellows in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and,** **(Core)**
1053
1054
1055
1056 **V.A.1.d).(3)** **develop plans for fellows failing to progress, following institutional policies and procedures.** **(Core)**
1057
1058

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

Fellows who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention,

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

1059
1060 **V.A.1.e)** **At least annually, there must be a summative evaluation of**
1061 **each fellow that includes their readiness to progress to the**
1062 **next year of the program, if applicable.** (Core)
1063
1064 **V.A.1.f)** **The evaluations of a fellow's performance must be accessible**
1065 **for review by the fellow.** (Core)
1066
1067 **V.A.2.** **Final Evaluation**
1068
1069 **V.A.2.a)** **The program director must provide a final evaluation for each**
1070 **fellow upon completion of the program.** (Core)
1071
1072 **V.A.2.a).(1)** **The subspecialty-specific Milestones, and when**
1073 **applicable the subspecialty-specific Case Logs, must**
1074 **be used as tools to ensure fellows are able to engage**
1075 **in autonomous practice upon completion of the**
1076 **program.** (Core)
1077
1078 **V.A.2.a).(2)** **The final evaluation must:**
1079
1080 **V.A.2.a).(2).(a)** **become part of the fellow's permanent record**
1081 **maintained by the institution, and must be**
1082 **accessible for review by the fellow in**
1083 **accordance with institutional policy;** (Core)
1084
1085 **V.A.2.a).(2).(b)** **verify that the fellow has demonstrated the**
1086 **knowledge, skills, and behaviors necessary to**
1087 **enter autonomous practice;** (Core)
1088
1089 **V.A.2.a).(2).(c)** **consider recommendations from the Clinical**
1090 **Competency Committee; and,** (Core)
1091
1092 **V.A.2.a).(2).(d)** **be shared with the fellow upon completion of**
1093 **the program.** (Core)
1094
1095 **V.A.3.** **A Clinical Competency Committee must be appointed by the**
1096 **program director.** (Core)
1097
1098 **V.A.3.a)** **At a minimum the Clinical Competency Committee must**
1099 **include three members, at least one of whom is a core faculty**
1100 **member. Members must be faculty members from the same**
1101 **program or other programs, or other health professionals**
1102 **who have extensive contact and experience with the**
1103 **program's fellows.** (Core)

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1104
1105 **V.A.3.b)** **The Clinical Competency Committee must:**
1106
1107 **V.A.3.b).(1)** **review all fellow evaluations at least semi-annually;**
1108 **(Core)**
1109
1110 **V.A.3.b).(2)** **determine each fellow's progress on achievement of**
1111 **the subspecialty-specific Milestones; and, (Core)**
1112
1113 **V.A.3.b).(3)** **meet prior to the fellows' semi-annual evaluations and**
1114 **advise the program director regarding each fellow's**
1115 **progress. (Core)**
1116
1117 **V.B.** **Faculty Evaluation**
1118
1119 **V.B.1.** **The program must have a process to evaluate each faculty**
1120 **member's performance as it relates to the educational program at**
1121 **least annually. (Core)**
1122

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

1123
1124 **V.B.1.a)** **This evaluation must include a review of the faculty member's**
1125 **clinical teaching abilities, engagement with the educational**
1126 **program, participation in faculty development related to their**
1127 **skills as an educator, clinical performance, professionalism,**
1128 **and scholarly activities. (Core)**
1129
1130 **V.B.1.b)** **This evaluation must include written, confidential evaluations**
1131 **by the fellows. (Core)**
1132
1133 **V.B.2.** **Faculty members must receive feedback on their evaluations at least**
1134 **annually. (Core)**
1135

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1136 **V.B.3.** **Results of the faculty educational evaluations should be**
1137 **incorporated into program-wide faculty development plans.** (Core)
1138

Background and Intent: The quality of the faculty's teaching and clinical care is a determinant of the quality of the program and the quality of the fellows' future clinical care. Therefore, the program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. This section mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

1139
1140 **V.C.** **Program Evaluation and Improvement**
1141
1142 **V.C.1.** **The program director must appoint the Program Evaluation**
1143 **Committee to conduct and document the Annual Program**
1144 **Evaluation as part of the program's continuous improvement**
1145 **process.** (Core)
1146
1147 **V.C.1.a)** **The Program Evaluation Committee must be composed of at**
1148 **least two program faculty members, at least one of whom is a**
1149 **core faculty member, and at least one fellow.** (Core)
1150
1151 **V.C.1.b)** **Program Evaluation Committee responsibilities must include:**
1152
1153 **V.C.1.b).(1)** **acting as an advisor to the program director, through**
1154 **program oversight;** (Core)
1155
1156 **V.C.1.b).(2)** **review of the program's self-determined goals and**
1157 **progress toward meeting them;** (Core)
1158
1159 **V.C.1.b).(3)** **guiding ongoing program improvement, including**
1160 **development of new goals, based upon outcomes;**
1161 **and,** (Core)
1162
1163 **V.C.1.b).(4)** **review of the current operating environment to identify**
1164 **strengths, challenges, opportunities, and threats as**
1165 **related to the program's mission and aims.** (Core)
1166

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

1167
1168 **V.C.1.c)** **The Program Evaluation Committee should consider the**
1169 **following elements in its assessment of the program:**
1170
1171 **V.C.1.c).(1)** **curriculum;** (Core)
1172
1173 **V.C.1.c).(2)** **outcomes from prior Annual Program Evaluation(s);**
1174 (Core)

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1175
1176 **V.C.1.c).(3)** **ACGME letters of notification, including citations,**
1177 **Areas for Improvement, and comments;** (Core)
1178
1179 **V.C.1.c).(4)** **quality and safety of patient care;** (Core)
1180
1181 **V.C.1.c).(5)** **aggregate fellow and faculty:**
1182
1183 **V.C.1.c).(5).(a)** **well-being;** (Core)
1184
1185 **V.C.1.c).(5).(b)** **recruitment and retention;** (Core)
1186
1187 **V.C.1.c).(5).(c)** **workforce diversity;** (Core)
1188
1189 **V.C.1.c).(5).(d)** **engagement in quality improvement and patient**
1190 **safety;** (Core)
1191
1192 **V.C.1.c).(5).(e)** **scholarly activity;** (Core)
1193
1194 **V.C.1.c).(5).(f)** **ACGME Resident/Fellow and Faculty Surveys**
1195 **(where applicable); and,** (Core)
1196
1197 **V.C.1.c).(5).(g)** **written evaluations of the program.** (Core)
1198
1199 **V.C.1.c).(6)** **aggregate fellow:**
1200
1201 **V.C.1.c).(6).(a)** **achievement of the Milestones;** (Core)
1202
1203 **V.C.1.c).(6).(b)** **in-training examinations (where applicable);**
1204 (Core)
1205
1206 **V.C.1.c).(6).(c)** **board pass and certification rates; and,** (Core)
1207
1208 **V.C.1.c).(6).(d)** **graduate performance.** (Core)
1209
1210 **V.C.1.c).(7)** **aggregate faculty:**
1211
1212 **V.C.1.c).(7).(a)** **evaluation; and,** (Core)
1213
1214 **V.C.1.c).(7).(b)** **professional development** (Core)
1215
1216 **V.C.1.d)** **The Program Evaluation Committee must evaluate the**
1217 **program's mission and aims, strengths, areas for**
1218 **improvement, and threats.** (Core)
1219
1220 **V.C.1.e)** **The annual review, including the action plan, must:**
1221
1222 **V.C.1.e).(1)** **be distributed to and discussed with the members of**
1223 **the teaching faculty and the fellows; and,** (Core)
1224
1225 **V.C.1.e).(2)** **be submitted to the DIO.** (Core)

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1226

1227 **V.C.2.** **The program must participate in a Self-Study prior to its 10-Year**
1228 **Accreditation Site Visit.** **(Core)**
1229

1230 **V.C.2.a)** **A summary of the Self-Study must be submitted to the DIO.**
1231 **(Core)**
1232

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

1233

1234 **V.C.3.** ***One goal of ACGME-accredited education is to educate physicians***
1235 ***who seek and achieve board certification. One measure of the***
1236 ***effectiveness of the educational program is the ultimate pass rate.***
1237

1238 ***The program director should encourage all eligible program***
1239 ***graduates to take the certifying examination offered by the***
1240 ***applicable American Board of Medical Specialties (ABMS) member***
1241 ***board or American Osteopathic Association (AOA) certifying board.***
1242

1243 **V.C.3.a)** **For subspecialties in which the ABMS member board and/or**
1244 **AOA certifying board offer(s) an annual written exam, in the**
1245 **preceding three years, the program's aggregate pass rate of**
1246 **those taking the examination for the first time must be higher**
1247 **than the bottom fifth percentile of programs in that**
1248 **subspecialty.** **(Outcome)**
1249

1250 **V.C.3.b)** **For subspecialties in which the ABMS member board and/or**
1251 **AOA certifying board offer(s) a biennial written exam, in the**
1252 **preceding six years, the program's aggregate pass rate of**
1253 **those taking the examination for the first time must be higher**
1254 **than the bottom fifth percentile of programs in that**
1255 **subspecialty.** **(Outcome)**
1256

1257 **V.C.3.c)** **For subspecialties in which the ABMS member board and/or**
1258 **AOA certifying board offer(s) an annual oral exam, in the**
1259 **preceding three years, the program's aggregate pass rate of**
1260 **those taking the examination for the first time must be higher**
1261 **than the bottom fifth percentile of programs in that**
1262 **subspecialty.** **(Outcome)**
1263

1264 **V.C.3.d)** **For subspecialties in which the ABMS member board and/or**
1265 **AOA certifying board offer(s) a biennial oral exam, in the**

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1266 **preceding six years, the program's aggregate pass rate of**
1267 **those taking the examination for the first time must be higher**
1268 **than the bottom fifth percentile of programs in that**
1269 **subspecialty.** **(Outcome)**
1270
1271 **V.C.3.e)** **For each of the exams referenced in V.C.3.a)-d), any program**
1272 **whose graduates over the time period specified in the**
1273 **requirement have achieved an 80 percent pass rate will have**
1274 **met this requirement, no matter the percentile rank of the**
1275 **program for pass rate in that subspecialty.** **(Outcome)**
1276

Background and Intent: Setting a single standard for pass rate that works across subspecialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform. There are subspecialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

1277
1278 **V.C.3.f)** **Programs must report, in ADS, board certification status**
1279 **annually for the cohort of board-eligible fellows that**
1280 **graduated seven years earlier.** **(Core)**
1281

Background and Intent: It is essential that fellowship programs demonstrate knowledge and skill transfer to their fellows. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from fellowship graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it. The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations. In the future, the ACGME may establish parameters related to ultimate board certification rates.

1282
1283 **VI. The Learning and Working Environment**
1284
1285 ***Fellowship education must occur in the context of a learning and working***
1286 ***environment that emphasizes the following principles:***
1287
1288 • ***Excellence in the safety and quality of care rendered to patients by fellows***
1289 ***today***
1290

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- ***Excellence in the safety and quality of care rendered to patients by today's fellows in their future practice***

- ***Excellence in professionalism through faculty modeling of:***

  - ***the effacement of self-interest in a humanistic environment that supports the professional development of physicians***

  - ***the joy of curiosity, problem-solving, intellectual rigor, and discovery***

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

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

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

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.

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

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

VI.A.1.a) Patient Safety

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

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

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

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

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

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

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

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

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

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1367
1368 **VI.A.1.a).(3).(a)** **Residents, fellows, faculty members, and other**
1369 **clinical staff members must:**
1370
1371 **VI.A.1.a).(3).(a).(i)** **know their responsibilities in reporting**
1372 **patient safety events at the clinical site;**
1373 **(Core)**
1374
1375 **VI.A.1.a).(3).(a).(ii)** **know how to report patient safety**
1376 **events, including near misses, at the**
1377 **clinical site; and, (Core)**
1378
1379 **VI.A.1.a).(3).(a).(iii)** **be provided with summary information**
1380 **of their institution's patient safety**
1381 **reports. (Core)**
1382
1383 **VI.A.1.a).(3).(b)** **Fellows must participate as team members in**
1384 **real and/or simulated interprofessional clinical**
1385 **patient safety activities, such as root cause**
1386 **analyses or other activities that include**
1387 **analysis, as well as formulation and**
1388 **implementation of actions. (Core)**
1389
1390 **VI.A.1.a).(4)** **Fellow Education and Experience in Disclosure of**
1391 **Adverse Events**
1392
1393 ***Patient-centered care requires patients, and when***
1394 ***appropriate families, to be apprised of clinical***
1395 ***situations that affect them, including adverse events.***
1396 ***This is an important skill for faculty physicians to***
1397 ***model, and for fellows to develop and apply.***
1398
1399 **VI.A.1.a).(4).(a)** **All fellows must receive training in how to**
1400 **disclose adverse events to patients and**
1401 **families. (Core)**
1402
1403 **VI.A.1.a).(4).(b)** **Fellows should have the opportunity to**
1404 **participate in the disclosure of patient safety**
1405 **events, real or simulated. (Detail)†**
1406
1407 **VI.A.1.b)** **Quality Improvement**
1408
1409 **VI.A.1.b).(1)** **Education in Quality Improvement**
1410
1411 ***A cohesive model of health care includes quality-***
1412 ***related goals, tools, and techniques that are necessary***
1413 ***in order for health care professionals to achieve***
1414 ***quality improvement goals.***
1415

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1416 **VI.A.1.b).(1).(a)** **Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities.** (Core)

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

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

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

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

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

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

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

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

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

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

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)

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1467 **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)**

1471 **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)**

1475 **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, 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.***

1486 **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)**

1493 **VI.A.2.c)** **Levels of Supervision**

1495 **To promote oversight of fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:** **(Core)**

1499 **VI.A.2.c).(1)** **Direct Supervision – the supervising physician is physically present with the fellow and patient.** **(Core)**

1502 **VI.A.2.c).(2)** **Indirect Supervision:**

1504 **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)**

1510 **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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1517 **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)**

1520

1521 **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)**

1525

1526 **VI.A.2.d).(1)** **The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones.** **(Core)**

1529

1530 **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)**

1534

1535 **VI.A.2.d).(3)** **Fellows should serve in a supervisory role to junior fellows and residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.** **(Detail)**

1540

1541 **VI.A.2.e)** **Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s).** **(Core)**

1544

1545 **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)**

1549

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

1550

1551 **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)**

1555

1556 **VI.B.** **Professionalism**

1557

1558 **VI.B.1.** **Programs, in partnership with their Sponsoring Institutions, must educate fellows and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients.** **(Core)**

1563

1564 **VI.B.2.** **The learning objectives of the program must:**

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1565
1566 **VI.B.2.a)** **be accomplished through an appropriate blend of supervised**
1567 **patient care responsibilities, clinical teaching, and didactic**
1568 **educational events;** (Core)
1569
1570 **VI.B.2.b)** **be accomplished without excessive reliance on fellows to**
1571 **fulfill non-physician obligations; and,** (Core)
1572

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

1573
1574 **VI.B.2.c)** **ensure manageable patient care responsibilities.** (Core)
1575

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

1576
1577 **VI.B.3.** **The program director, in partnership with the Sponsoring Institution,**
1578 **must provide a culture of professionalism that supports patient**
1579 **safety and personal responsibility.** (Core)
1580
1581 **VI.B.4.** **Fellows and faculty members must demonstrate an understanding**
1582 **of their personal role in the:**
1583
1584 **VI.B.4.a)** **provision of patient- and family-centered care;** (Outcome)
1585
1586 **VI.B.4.b)** **safety and welfare of patients entrusted to their care,**
1587 **including the ability to report unsafe conditions and adverse**
1588 **events;** (Outcome)
1589

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

1590
1591 **VI.B.4.c)** **assurance of their fitness for work, including:** (Outcome)
1592

Background and Intent: This requirement emphasizes the professional responsibility of faculty members and fellows to arrive for work adequately rested and ready to care for

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patients. It is also the responsibility of faculty members, fellows, and other members of the care team to be observant, to intervene, and/or to escalate their concern about fellow and faculty member fitness for work, depending on the situation, and in accordance with institutional policies.

1593
1594 **VI.B.4.c).(1)** **management of their time before, during, and after**
1595 **clinical assignments; and,** (Outcome)
1596
1597 **VI.B.4.c).(2)** **recognition of impairment, including from illness,**
1598 **fatigue, and substance use, in themselves, their peers,**
1599 **and other members of the health care team.** (Outcome)
1600
1601 **VI.B.4.d)** **commitment to lifelong learning;** (Outcome)
1602
1603 **VI.B.4.e)** **monitoring of their patient care performance improvement**
1604 **indicators; and,** (Outcome)
1605
1606 **VI.B.4.f)** **accurate reporting of clinical and educational work hours,**
1607 **patient outcomes, and clinical experience data.** (Outcome)
1608
1609 **VI.B.5.** **All fellows and faculty members must demonstrate responsiveness**
1610 **to patient needs that supersedes self-interest. This includes the**
1611 **recognition that under certain circumstances, the best interests of**
1612 **the patient may be served by transitioning that patient's care to**
1613 **another qualified and rested provider.** (Outcome)
1614
1615 **VI.B.6.** **Programs, in partnership with their Sponsoring Institutions, must**
1616 **provide a professional, equitable, respectful, and civil environment**
1617 **that is free from discrimination, sexual and other forms of**
1618 **harassment, mistreatment, abuse, or coercion of students, fellows,**
1619 **faculty, and staff.** (Core)
1620
1621 **VI.B.7.** **Programs, in partnership with their Sponsoring Institutions, should**
1622 **have a process for education of fellows and faculty regarding**
1623 **unprofessional behavior and a confidential process for reporting,**
1624 **investigating, and addressing such concerns.** (Core)
1625
1626 **VI.C.** **Well-Being**
1627
1628 ***Psychological, emotional, and physical well-being are critical in the***
1629 ***development of the competent, caring, and resilient physician and require***
1630 ***proactive attention to life inside and outside of medicine. Well-being***
1631 ***requires that physicians retain the joy in medicine while managing their***
1632 ***own real life stresses. Self-care and responsibility to support other***
1633 ***members of the health care team are important components of***
1634 ***professionalism; they are also skills that must be modeled, learned, and***
1635 ***nurtured in the context of other aspects of fellowship training.***
1636
1637 ***Fellows and faculty members are at risk for burnout and depression.***
1638 ***Programs, in partnership with their Sponsoring Institutions, have the same***
1639 ***responsibility to address well-being as other aspects of resident***

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1640 ***competence. Physicians and all members of the health care team share***
1641 ***responsibility for the well-being of each other. For example, a culture which***
1642 ***encourages covering for colleagues after an illness without the expectation***
1643 ***of reciprocity reflects the ideal of professionalism. A positive culture in a***
1644 ***clinical learning environment models constructive behaviors, and prepares***
1645 ***fellows with the skills and attitudes needed to thrive throughout their***
1646 ***careers.***
1647

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

1648
1649 **VI.C.1.** **The responsibility of the program, in partnership with the**
1650 **Sponsoring Institution, to address well-being must include:**
1651
1652 **VI.C.1.a)** **efforts to enhance the meaning that each fellow finds in the**
1653 **experience of being a physician, including protecting time**
1654 **with patients, minimizing non-physician obligations,**
1655 **providing administrative support, promoting progressive**
1656 **autonomy and flexibility, and enhancing professional**
1657 **relationships; (Core)**
1658
1659 **VI.C.1.b)** **attention to scheduling, work intensity, and work**
1660 **compression that impacts fellow well-being; (Core)**
1661
1662 **VI.C.1.c)** **evaluating workplace safety data and addressing the safety of**
1663 **fellows and faculty members; (Core)**
1664

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

1665
1666 **VI.C.1.d)** **policies and programs that encourage optimal fellow and**
1667 **faculty member well-being; and, (Core)**
1668

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

1669
1670 **VI.C.1.d).(1)** **Fellows must be given the opportunity to attend**
1671 **medical, mental health, and dental care appointments,**
1672 **including those scheduled during their working hours.**
1673 **(Core)**
1674

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

1675
1676 **VI.C.1.e)** **attention to fellow and faculty member burnout, depression,**
1677 **and substance abuse. The program, in partnership with its**
1678 **Sponsoring Institution, must educate faculty members and**
1679 **fellows in identification of the symptoms of burnout,**
1680 **depression, and substance abuse, including means to assist**
1681 **those who experience these conditions. Fellows and faculty**
1682 **members must also be educated to recognize those**
1683 **symptoms in themselves and how to seek appropriate care.**
1684 **The program, in partnership with its Sponsoring Institution,**
1685 **must: (Core)**
1686

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

1687
1688 **VI.C.1.e).(1)** **encourage fellows and faculty members to alert the**
1689 **program director or other designated personnel or**
1690 **programs when they are concerned that another**
1691 **fellow, resident, or faculty member may be displaying**
1692 **signs of burnout, depression, substance abuse,**
1693 **suicidal ideation, or potential for violence; (Core)**
1694

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

physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

1695
1696 **VI.C.1.e).(2)** **provide access to appropriate tools for self-screening;**
1697 **and,** (Core)
1698
1699 **VI.C.1.e).(3)** **provide access to confidential, affordable mental**
1700 **health assessment, counseling, and treatment,**
1701 **including access to urgent and emergent care 24**
1702 **hours a day, seven days a week.** (Core)
1703

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

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

1704
1705 **VI.C.2.** **There are circumstances in which fellows may be unable to attend**
1706 **work, including but not limited to fatigue, illness, family**
1707 **emergencies, and parental leave. Each program must allow an**
1708 **appropriate length of absence for fellows unable to perform their**
1709 **patient care responsibilities.** (Core)
1710
1711 **VI.C.2.a)** **The program must have policies and procedures in place to**
1712 **ensure coverage of patient care.** (Core)
1713
1714 **VI.C.2.b)** **These policies must be implemented without fear of negative**
1715 **consequences for the fellow who is or was unable to provide**
1716 **the clinical work.** (Core)
1717

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

1718
1719 **VI.D.** **Fatigue Mitigation**
1720
1721 **VI.D.1.** **Programs must:**
1722
1723 **VI.D.1.a)** **educate all faculty members and fellows to recognize the**
1724 **signs of fatigue and sleep deprivation;** (Core)
1725
1726 **VI.D.1.b)** **educate all faculty members and fellows in alertness**
1727 **management and fatigue mitigation processes; and,** (Core)
1728

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1729 **VI.D.1.c)** **encourage fellows to use fatigue mitigation processes to**
1730 **manage the potential negative effects of fatigue on patient**
1731 **care and learning.** (Detail)
1732

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

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

1733
1734 **VI.D.2.** **Each program must ensure continuity of patient care, consistent**
1735 **with the program's policies and procedures referenced in VI.C.2–**
1736 **VI.C.2.b), in the event that a fellow may be unable to perform their**
1737 **patient care responsibilities due to excessive fatigue.** (Core)
1738
1739 **VI.D.3.** **The program, in partnership with its Sponsoring Institution, must**
1740 **ensure adequate sleep facilities and safe transportation options for**
1741 **fellows who may be too fatigued to safely return home.** (Core)
1742
1743 **VI.E.** **Clinical Responsibilities, Teamwork, and Transitions of Care**
1744
1745 **VI.E.1.** **Clinical Responsibilities**
1746
1747 **The clinical responsibilities for each fellow must be based on PGY**
1748 **level, patient safety, fellow ability, severity and complexity of patient**
1749 **illness/condition, and available support services.** (Core)
1750

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

1751
1752 **VI.E.2.** **Teamwork**
1753
1754 **Fellows must care for patients in an environment that maximizes**
1755 **communication. This must include the opportunity to work as a**

1756 **member of effective interprofessional teams that are appropriate to**
1757 **the delivery of care in the subspecialty and larger health system.**
1758 **(Core)**
1759
1760 VI.E.2.a) Contributors to effective interprofessional teams may include
1761 consulting physicians, paramedics, emergency medical
1762 technicians, nurses, firefighters, police officers, and other
1763 professional and paraprofessional personnel involved in the
1764 assessment and treatment of patients. (Detail)
1765
1766 **VI.E.3. Transitions of Care**
1767
1768 **VI.E.3.a) Programs must design clinical assignments to optimize**
1769 **transitions in patient care, including their safety, frequency,**
1770 **and structure. (Core)**
1771
1772 **VI.E.3.b) Programs, in partnership with their Sponsoring Institutions,**
1773 **must ensure and monitor effective, structured hand-over**
1774 **processes to facilitate both continuity of care and patient**
1775 **safety. (Core)**
1776
1777 **VI.E.3.c) Programs must ensure that fellows are competent in**
1778 **communicating with team members in the hand-over process.**
1779 **(Outcome)**
1780
1781 **VI.E.3.d) Programs and clinical sites must maintain and communicate**
1782 **schedules of attending physicians and fellows currently**
1783 **responsible for care. (Core)**
1784
1785 **VI.E.3.e) Each program must ensure continuity of patient care,**
1786 **consistent with the program's policies and procedures**
1787 **referenced in VI.C.2-VI.C.2.b), in the event that a fellow may**
1788 **be unable to perform their patient care responsibilities due to**
1789 **excessive fatigue or illness, or family emergency. (Core)**
1790
1791 **VI.F. Clinical Experience and Education**
1792
1793 ***Programs, in partnership with their Sponsoring Institutions, must design***
1794 ***an effective program structure that is configured to provide fellows with***
1795 ***educational and clinical experience opportunities, as well as reasonable***
1796 ***opportunities for rest and personal activities.***
1797

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

1798
1799 **VI.F.1. Maximum Hours of Clinical and Educational Work per Week**
1800

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1801 **Clinical and educational work hours must be limited to no more than**
1802 **80 hours per week, averaged over a four-week period, inclusive of all**
1803 **in-house clinical and educational activities, clinical work done from**
1804 **home, and all moonlighting.** (Core)
1805

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

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

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

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

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

1806
1807 **VI.F.2. Mandatory Time Free of Clinical Work and Education**
1808
1809 **VI.F.2.a) The program must design an effective program structure that**
1810 **is configured to provide fellows with educational**
1811 **opportunities, as well as reasonable opportunities for rest**
1812 **and personal well-being.** (Core)
1813
1814 **VI.F.2.b) Fellows should have eight hours off between scheduled**
1815 **clinical work and education periods.** (Detail)
1816
1817 **VI.F.2.b).(1) There may be circumstances when fellows choose to**
1818 **stay to care for their patients or return to the hospital**
1819 **with fewer than eight hours free of clinical experience**
1820 **and education. This must occur within the context of**
1821 **the 80-hour and the one-day-off-in-seven**
1822 **requirements.** (Detail)
1823

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

1824
1825 **VI.F.2.c) Fellows must have at least 14 hours free of clinical work and**
1826 **education after 24 hours of in-house call.** (Core)
1827

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

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1828
1829 **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)**
1830
1831
1832
1833

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and fellow needs. It is strongly recommended that fellows' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some fellows may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide fellows with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes fellow well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."

1834
1835 **VI.F.3.** **Maximum Clinical Work and Education Period Length**
1836
1837 **VI.F.3.a)** **Clinical and educational work periods for fellows must not exceed 24 hours of continuous scheduled clinical assignments.** **(Core)**
1838
1839
1840
1841 **VI.F.3.a).(1)** **Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or fellow education.** **(Core)**
1842
1843
1844
1845
1846 **VI.F.3.a).(1).(a)** **Additional patient care responsibilities must not be assigned to a fellow during this time.** **(Core)**
1847
1848

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

1849
1850 **VI.F.4.** **Clinical and Educational Work Hour Exceptions**
1851
1852 **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:**
1853
1854
1855
1856

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1857 **VI.F.4.a).(1)** **to continue to provide care to a single severely ill or**
1858 **unstable patient;** (Detail)
1859
1860 **VI.F.4.a).(2)** **humanistic attention to the needs of a patient or**
1861 **family; or,** (Detail)
1862
1863 **VI.F.4.a).(3)** **to attend unique educational events.** (Detail)
1864
1865 **VI.F.4.b)** **These additional hours of care or education will be counted**
1866 **toward the 80-hour weekly limit.** (Detail)
1867

Background and Intent: This requirement is intended to provide fellows with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a fellow may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Fellows must not be required to stay. Programs allowing fellows to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the fellow and that fellows are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

1868
1869 **VI.F.4.c)** **A Review Committee may grant rotation-specific exceptions**
1870 **for up to 10 percent or a maximum of 88 clinical and**
1871 **educational work hours to individual programs based on a**
1872 **sound educational rationale.**
1873
1874 The Review Committee for Emergency Medicine will not consider
1875 requests for exceptions to the 80-hour limit to the fellows' work
1876 week.
1877
1878 **VI.F.4.c).(1)** **In preparing a request for an exception, the program**
1879 **director must follow the clinical and educational work**
1880 **hour exception policy from the *ACGME Manual of***
1881 ***Policies and Procedures*.** (Core)
1882
1883 **VI.F.4.c).(2)** **Prior to submitting the request to the Review**
1884 **Committee, the program director must obtain approval**
1885 **from the Sponsoring Institution's GMEC and DIO.** (Core)
1886

Background and Intent: The provision for exceptions for up to 88 hours per week has been modified to specify that exceptions may be granted for specific rotations if the program can justify the increase based on criteria specified by the Review Committee. As in the past, Review Committees may opt not to permit exceptions. The underlying philosophy for this requirement is that while it is expected that all fellows should be able to train within an 80-hour work week, it is recognized that some programs may include rotations with alternate structures based on the nature of the specialty. DIO/GMEC approval is required before the request will be considered by the Review Committee.

1887
1888 **VI.F.5.** **Moonlighting**

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1889
1890 **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)
1894
1895 **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)
1898

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

1899
1900 **VI.F.6.** **In-House Night Float**
1901
1902 **Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.** (Core)
1904

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

1905
1906 **VI.F.7.** **Maximum In-House On-Call Frequency**
1907
1908 **Fellows must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).** (Core)
1910
1911 **VI.F.8.** **At-Home Call**
1912
1913 **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)
1919
1920 **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)
1923
1924 **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)
1928

Background and Intent: This requirement has been modified to specify that clinical work done from home when a fellow is taking at-home call must count toward the 80-hour maximum weekly limit. This change acknowledges the often significant amount of time fellows devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in fellows routinely working more than 80 hours per week. At-

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home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

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

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

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

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

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

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