

**ACGME Program Requirements for
Graduate Medical Education
in Female Pelvic Medicine and Reconstructive Surgery**

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1 **Proposed ACGME Program Requirements for Graduate Medical Education**
2 **in Female Pelvic Medicine and Reconstructive Surgery**

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

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

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

10
11 **Introduction**

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

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

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

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

48
49 Female pelvic medicine and reconstructive surgery physicians provide
50 specialized services and comprehensive management of women with pelvic floor
51 disorders. Comprehensive management includes the preventative, diagnostic,
52 and therapeutic procedures necessary for the total care of the female patient,
53 including complications and sequelae resulting from pelvic floor disorders.
54

55 **Int.C. Length of Educational Program**

56
57 Int.C.1. The educational program for obstetrics and gynecology graduates must
58 be 36 months in length. ^(Core)

59
60 Int.C.2. The educational program for urology graduates must be at least 24
61 months in length. ^(Core)

62
63 **I. Oversight**

64
65 **I.A. Sponsoring Institution**

66
67 *The Sponsoring Institution is the organization or entity that assumes the*
68 *ultimate financial and academic responsibility for a program of graduate*
69 *medical education consistent with the ACGME Institutional Requirements.*

70
71 *When the Sponsoring Institution is not a rotation site for the program, the*
72 *most commonly utilized site of clinical activity for the program is the*
73 *primary clinical site.*
74

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.

75
76 **I.A.1. The program must be sponsored by one ACGME-accredited**
77 **Sponsoring Institution.** ^(Core)

78
79 **I.B. Participating Sites**

80
81 *A participating site is an organization providing educational experiences or*
82 *educational assignments/rotations for fellows.*

83
84 **I.B.1. The program, with approval of its Sponsoring Institution, must**
85 **designate a primary clinical site.** ^(Core)

86
87 I.B.1.a) The Sponsoring Institution must also sponsor an ACGME-
88 accredited residency program in either obstetrics and gynecology
89 or urology. ^(Core)

- 90
91 I.B.1.a).(1) The program must be associated with and meaningfully
92 involved in the ACGME-accredited residency program in
93 either obstetrics and gynecology or urology. ^(Core)
94
95 **I.B.2.** **There must be a program letter of agreement (PLA) between the**
96 **program and each participating site that governs the relationship**
97 **between the program and the participating site providing a required**
98 **assignment.** ^(Core)
99
100 **I.B.2.a)** **The PLA must:**
101
102 **I.B.2.a).(1)** **be renewed at least every 10 years; and,** ^(Core)
103
104 **I.B.2.a).(2)** **be approved by the designated institutional official**
105 **(DIO).** ^(Core)
106
107 **I.B.3.** **The program must monitor the clinical learning and working**
108 **environment at all participating sites.** ^(Core)
109
110 **I.B.3.a)** **At each participating site there must be one faculty member,**
111 **designated by the program director, who is accountable for**
112 **fellow education for that site, in collaboration with the**
113 **program director.** ^(Core)
114

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**

- 115
116 **I.B.4.** **The program director must submit any additions or deletions of**
117 **participating sites routinely providing an educational experience,**
118 **required for all fellows, of one month full time equivalent (FTE) or**
119 **more through the ACGME's Accreditation Data System (ADS).** ^(Core)

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

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

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I.D. Resources

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

I.D.1.a) The primary clinical site must include operating rooms, ambulatory clinic facilities, recovery rooms, intensive care units, blood banks, diagnostic laboratories, and imaging services. ^(Core)

I.D.1.a).(1) Access to appropriate facilities for the management of complications must be available at all times. ^(Core)

I.D.1.b) Research infrastructure must be adequate in scope, equipment, statistical support, and personnel to conduct scholarly activity. ^(Core)

I.D.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote fellow well-being and provide for: ^(Core)

I.D.2.a) access to food while on duty; ^(Core)

I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available and accessible for fellows with proximity appropriate for safe patient care; ^(Core)

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

154

155 I.D.2.c) clean and private facilities for lactation that have refrigeration
156 capabilities, with proximity appropriate for safe patient care;
157 (Core)
158

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).

159
160 I.D.2.d) security and safety measures appropriate to the participating
161 site; and, (Core)
162

163 I.D.2.e) accommodations for fellows with disabilities consistent with
164 the Sponsoring Institution's policy. (Core)
165

166 I.D.3. Fellows must have ready access to subspecialty-specific and other
167 appropriate reference material in print or electronic format. This
168 must include access to electronic medical literature databases with
169 full text capabilities. (Core)
170

171 I.D.4. The program's educational and clinical resources must be adequate
172 to support the number of fellows appointed to the program. (Core)
173

174 I.E. *A fellowship program usually occurs in the context of many learners and
175 other care providers and limited clinical resources. It should be structured
176 to optimize education for all learners present.*
177

178 I.E.1. Fellows should contribute to the education of residents in core
179 programs, if present. (Core)
180

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.

181
182 II. Personnel
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184 II.A. Program Director
185

186 II.A.1. There must be one faculty member appointed as program director
187 with authority and accountability for the overall program, including
188 compliance with all applicable program requirements. (Core)
189

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

193
194 **II.A.1.b) Final approval of the program director resides with the**
195 **Review Committee. (Core)**
196

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.

197
198 **II.A.2. The program director must be provided with support adequate for**
199 **administration of the program based upon its size and configuration.**
200 **(Core)**

201
202 **II.A.2.a) At a minimum, the program director must be provided with the**
203 **salary support required to devote 20 percent FTE of non-clinical**
204 **time to the administration of the program. (Core)**
205

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

“Administrative time” is defined as non-clinical time spent meeting the responsibilities of the program director as detailed in requirements II.A.4.-II.A.4.a).(16).

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

206
207 **II.A.3. Qualifications of the program director:**

208
209 **II.A.3.a) must include subspecialty expertise and qualifications**
210 **acceptable to the Review Committee; (Core)**

211
212 **II.A.3.b) must include current certification in the subspecialty for**
213 **which they are the program director by the American Board**
214 **of Obstetrics and Gynecology or the American Board of Urology,**
215 **or by the American Osteopathic Board of Obstetrics and**
216 **Gynecology, or subspecialty qualifications that are acceptable**
217 **to the Review Committee; (Core)**

218
219 **II.A.3.c) must include completion of a female pelvic medicine and**
220 **reconstructive surgery fellowship at least five years prior to**
221 **appointment as the program director, or possess qualifications**
222 **acceptable to the Review Committee; and, (Core)**
223

Specialty-Specific Background and Intent: The Committee believes five years of experience as a female pelvic medicine and reconstructive surgery physician provides a new program director with the clinical, educational, research, and administrative background needed to

effectively lead a program. The Committee will consider a candidate for program director who has fewer than five years of experience provided the faculty member demonstrates clinical and scholarly expertise in female pelvic medicine and reconstructive surgery, is exceptionally well-prepared and positioned to take on this leadership position, and has mentorship and support by at least one faculty member that can be documented.

224
225 II.A.3.d) must include demonstration of clinical and scholarly activity in
226 female pelvic medicine and reconstructive surgery by publication
227 of a minimum of one original research or review article in a peer-
228 reviewed journal within the past three years and at least one of the
229 following within the past three years: ^(Core)

230
231 II.A.3.d).(1) peer-reviewed funding; ^(Core)

232
233 II.A.3.d).(2) invited or research presentation(s) at
234 regional/national/international professional or scientific
235 society meeting(s); or, ^(Core)

236
237 II.A.3.d).(3) participation on a committee of a national or international
238 professional, scientific, or educational organization. ^(Core)

239
240 **II.A.4. Program Director Responsibilities**

241
242 **The program director must have responsibility, authority, and**
243 **accountability for: administration and operations; teaching and**
244 **scholarly activity; fellow recruitment and selection, evaluation, and**
245 **promotion of fellows, and disciplinary action; supervision of fellows;**
246 **and fellow education in the context of patient care. ^(Core)**

247
248 **II.A.4.a) The program director must:**

249
250 **II.A.4.a).(1) be a role model of professionalism; ^(Core)**

251
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.

252
253 **II.A.4.a).(2) design and conduct the program in a fashion**
254 **consistent with the needs of the community, the**
255 **mission(s) of the Sponsoring Institution, and the**
256 **mission(s) of the program; ^(Core)**

257
Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design

and implementation of the program curriculum, with the ultimate goal of addressing these needs and health disparities.

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

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

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- II.A.4.a).(4) develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the fellowship program education and at least annually thereafter, as outlined in V.B.; ^(Core)

- II.A.4.a).(5) have the authority to approve program faculty members for participation in the fellowship program education at all sites; ^(Core)

- II.A.4.a).(6) have the authority to remove program faculty members from participation in the fellowship program education at all sites; ^(Core)

- II.A.4.a).(7) have the authority to remove fellows from supervising interactions and/or learning environments that do not meet the standards of the program; ^(Core)

Background and Intent: The program director has the responsibility to ensure that all who educate fellows effectively role model the Core Competencies. Working with a fellow is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.

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

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- II.A.4.a).(8) submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; ^(Core)

- II.A.4.a).(9) provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant subspecialty board examination(s); ^(Core)

- II.A.4.a).(10) provide a learning and working environment in which fellows have the opportunity to raise concerns and provide feedback in a confidential manner as

- 292 appropriate, without fear of intimidation or retaliation;
 293 (Core)
 294
 295 **II.A.4.a).(11)** ensure the program’s compliance with the Sponsoring
 296 Institution’s policies and procedures related to
 297 grievances and due process; (Core)
 298
 299 **II.A.4.a).(12)** ensure the program’s compliance with the Sponsoring
 300 Institution’s policies and procedures for due process
 301 when action is taken to suspend or dismiss, not to
 302 promote, or not to renew the appointment of a fellow;
 303 (Core)
 304

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.

- 305
 306 **II.A.4.a).(13)** ensure the program’s compliance with the Sponsoring
 307 Institution’s policies and procedures on employment
 308 and non-discrimination; (Core)
 309
 310 **II.A.4.a).(13).(a)** Fellows must not be required to sign a non-
 311 competition guarantee or restrictive covenant.
 312 (Core)
 313
 314 **II.A.4.a).(14)** document verification of program completion for all
 315 graduating fellows within 30 days; (Core)
 316
 317 **II.A.4.a).(15)** provide verification of an individual fellow’s
 318 completion upon the fellow’s request, within 30 days;
 319 and, (Core)
 320

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.

- 321
 322 **II.A.4.a).(16)** obtain review and approval of the Sponsoring
 323 Institution’s DIO before submitting information or
 324 requests to the ACGME, as required in the Institutional
 325 Requirements and outlined in the ACGME Program
 326 Director’s Guide to the Common Program
 327 Requirements. (Core)
 328
 329 **II.B. Faculty**
 330
 331 *Faculty members are a foundational element of graduate medical education*
 332 *– faculty members teach fellows how to care for patients. Faculty members*

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

343
344 *Faculty members ensure that patients receive the level of care expected*
345 *from a specialist in the field. They recognize and respond to the needs of*
346 *the patients, fellows, community, and institution. Faculty members provide*
347 *appropriate levels of supervision to promote patient safety. Faculty*
348 *members create an effective learning environment by acting in a*
349 *professional manner and attending to the well-being of the fellows and*
350 *themselves.*
351

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.

- 352
353 **II.B.1.** For each participating site, there must be a sufficient number of
354 faculty members with competence to instruct and supervise all
355 fellows at that location. ^(Core)
356
357 II.B.1.a) The program must have: ^(Core)
358
359 II.B.1.a).(1) at least one faculty member who is a urologist certified by
360 the American Board of Urology in female pelvic medicine
361 and reconstructive surgery, or who possesses other
362 qualifications acceptable to the Review Committee; and,
363 ^(Core)
364
365 II.B.1.a).(2) at least one faculty member who is an obstetrician-
366 gynecologist certified by the American Board of Obstetrics
367 and Gynecology or the American Osteopathic Board of
368 Obstetrics and Gynecology in female pelvic medicine and
369 reconstructive surgery, or who possesses other
370 qualifications acceptable to the Review Committee. ^(Core)
371
372 **II.B.2.** Faculty members must:
373
374 **II.B.2.a)** be role models of professionalism; ^(Core)
375
376 **II.B.2.b)** demonstrate commitment to the delivery of safe, quality,
377 cost-effective, patient-centered care; ^(Core)
378

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.

- 379
380 **II.B.2.c)** demonstrate a strong interest in the education of fellows; ^(Core)
381
382 **II.B.2.d)** devote sufficient time to the educational program to fulfill
383 their supervisory and teaching responsibilities; ^(Core)
384
385 **II.B.2.e)** administer and maintain an educational environment
386 conducive to educating fellows; ^(Core)
387
388 **II.B.2.f)** regularly participate in organized clinical discussions,
389 rounds, journal clubs, and conferences; and, ^(Core)
390
391 **II.B.2.g)** pursue faculty development designed to enhance their skills
392 at least annually. ^(Core)
393

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.

- 394
395 **II.B.3. Faculty Qualifications**
396
397 **II.B.3.a)** Faculty members must have appropriate qualifications in
398 their field and hold appropriate institutional appointments.
399 ^(Core)
400
401 **II.B.3.b)** Subspecialty physician faculty members must:
402
403 **II.B.3.b).(1)** have current certification in the subspecialty by the
404 **American Board of Obstetrics and Gynecology** or
405 **Urology, or the American Osteopathic Board of**
406 **Obstetrics and Gynecology, or possess qualifications**
407 **judged acceptable to the Review Committee.** ^(Core)
408
409 **II.B.3.c)** Any non-physician faculty members who participate in
410 fellowship program education must be approved by the
411 program director. ^(Core)
412

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.

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

420
421 **II.B.3.d).(1)** There must be physician faculty members with special
422 interest and expertise in anorectal disorders (fecal
423 incontinence, functional anorectal pain, and functional
424 defecation disorders) and rectovaginal and anovaginal
425 fistulae. ^(Core)

426
427 **II.B.3.d).(1).(a)** These faculty members may include a colorectal
428 surgeon, gastroenterologist, and/or female pelvic
429 medicine and reconstructive surgery subspecialist.
430 A female pelvic medicine and reconstructive
431 surgery subspecialist must have qualifications
432 acceptable to the Review Committee. ^(Core)

433
434 **II.B.4. Core Faculty**
435
436 **Core faculty members must have a significant role in the education**
437 **and supervision of fellows and must devote a significant portion of**
438 **their entire effort to fellow education and/or administration, and**
439 **must, as a component of their activities, teach, evaluate, and provide**
440 **formative feedback to fellows.** ^(Core)
441

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.

442
443 **II.B.4.a)** **Core faculty members must be designated by the program**
444 **director.** ^(Core)

445
446 **II.B.4.b)** **Core faculty members must complete the annual ACGME**
447 **Faculty Survey.** ^(Core)
448

449 **II.B.4.c)** In addition to the program director, there must be at least one core
450 program faculty member who is certified in female pelvic medicine
451 and reconstructive surgery by the American Board of Obstetrics
452 and Gynecology, the American Board of Urology, or the American
453 Osteopathic Board of Obstetrics and Gynecology. ^(Core)
454

455 **II.B.4.d)** In addition to the program director, there must be at least one core

456 faculty member who is qualified and available to mentor fellows'
457 research and scholarly activities. (Core)

458
459 **II.C. Program Coordinator**

460
461 **II.C.1. There must be a program coordinator. (Core)**

462
463 **II.C.2. The program coordinator must be provided with support adequate**
464 **for administration of the program based upon its size and**
465 **configuration. (Core)**

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

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

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

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

467
468 **II.D. Other Program Personnel**

469
470 **The program, in partnership with its Sponsoring Institution, must jointly**
471 **ensure the availability of necessary personnel for the effective**
472 **administration of the program. (Core)**

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

474
475 **III. Fellow Appointments**

476
477 **III.A. Eligibility Criteria**

478
479 **III.A.1. Eligibility Requirements – Fellowship Programs**

480

481 All required clinical education for entry into ACGME-accredited
482 fellowship programs must be completed in an ACGME-accredited
483 residency program, an AOA-approved residency program, a
484 program with ACGME International (ACGME-I) Advanced Specialty
485 Accreditation, or a Royal College of Physicians and Surgeons of
486 Canada (RCPSC)-accredited or College of Family Physicians of
487 Canada (CFPC)-accredited residency program located in Canada.
488 (Core)
489

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).

- 490
491 **III.A.1.a) Fellowship programs must receive verification of each**
492 **entering fellow’s level of competence in the required field,**
493 **upon matriculation, using ACGME, ACGME-I, or CanMEDS**
494 **Milestones evaluations from the core residency program. (Core)**
495
496 **III.A.1.b) Prerequisite Post-Graduate Clinical Education**
497
498 **III.A.1.b).(1) To be eligible for appointment to a 24-month educational**
499 **program, an individual must have completed a urology**
500 **residency program that satisfies the requirements in III.A.1.**
501 **(Core)**
502
503 **III.A.1.b).(2) To be eligible for appointment to a 36-month educational**
504 **program, an individual must have completed an obstetrics**
505 **and gynecology or urology residency program that satisfies**
506 **the requirements in III.A.1. (Core)**
507
508 **III.A.1.c) Fellow Eligibility Exception**
509
510 **The Review Committee for Obstetrics and Gynecology will allow**
511 **the following exception to the fellowship eligibility**
512 **requirements:**
513
514 **III.A.1.c).(1) An ACGME-accredited fellowship program may accept**
515 **an exceptionally qualified international graduate**
516 **applicant who does not satisfy the eligibility**
517 **requirements listed in III.A.1., but who does meet all of**
518 **the following additional qualifications and conditions:**
519 **(Core)**
520
521 **III.A.1.c).(1).(a) evaluation by the program director and**
522 **fellowship selection committee of the**
523 **applicant’s suitability to enter the program,**
524 **based on prior training and review of the**
525 **summative evaluations of training in the core**
526 **specialty; and, (Core)**
527

- 528 III.A.1.c).(1).(b) review and approval of the applicant's
 529 exceptional qualifications by the GMEC; and,
 530 (Core)
 531
 532 III.A.1.c).(1).(c) verification of Educational Commission for
 533 Foreign Medical Graduates (ECFMG)
 534 certification. (Core)
 535
 536 III.A.1.c).(2) Applicants accepted through this exception must have
 537 an evaluation of their performance by the Clinical
 538 Competency Committee within 12 weeks of
 539 matriculation. (Core)
 540

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.

- 541
 542 III.B. The program director must not appoint more fellows than approved by the
 543 Review Committee. (Core)
 544
 545 III.B.1. All complement increases must be approved by the Review
 546 Committee. (Core)
 547
 548 III.B.2. There should be at least two fellows in the program at all times. (Detail)
 549
 550 III.C. Fellow Transfers
 551
 552 The program must obtain verification of previous educational experiences
 553 and a summative competency-based performance evaluation prior to
 554 acceptance of a transferring fellow, and Milestones evaluations upon
 555 matriculation. (Core)
 556
 557 IV. Educational Program
 558
 559 *The ACGME accreditation system is designed to encourage excellence and*
 560 *innovation in graduate medical education regardless of the organizational*
 561 *affiliation, size, or location of the program.*
 562

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

565
566 ***In addition, the program is expected to define its specific program aims consistent***
567 ***with the overall mission of its Sponsoring Institution, the needs of the community***
568 ***it serves and that its graduates will serve, and the distinctive capabilities of***
569 ***physicians it intends to graduate. While programs must demonstrate substantial***
570 ***compliance with the Common and subspecialty-specific Program Requirements, it***
571 ***is recognized that within this framework, programs may place different emphasis***
572 ***on research, leadership, public health, etc. It is expected that the program aims***
573 ***will reflect the nuanced program-specific goals for it and its graduates; for***
574 ***example, it is expected that a program aiming to prepare physician-scientists will***
575 ***have a different curriculum from one focusing on community health.***

576
577 **IV.A. The curriculum must contain the following educational components: (Core)**

578
579 **IV.A.1. a set of program aims consistent with the Sponsoring Institution’s**
580 **mission, the needs of the community it serves, and the desired**
581 **distinctive capabilities of its graduates; (Core)**

582
583 **IV.A.1.a) The program’s aims must be made available to program**
584 **applicants, fellows, and faculty members. (Core)**

585
586 **IV.A.2. competency-based goals and objectives for each educational**
587 **experience designed to promote progress on a trajectory to**
588 **autonomous practice in their subspecialty. These must be**
589 **distributed, reviewed, and available to fellows and faculty members;**
590 **(Core)**

591
592 **IV.A.3. delineation of fellow responsibilities for patient care, progressive**
593 **responsibility for patient management, and graded supervision in**
594 **their subspecialty; (Core)**

595
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.

596
597 **IV.A.4. structured educational activities beyond direct patient care; and,**
598 **(Core)**

599
Background and Intent: Patient care-related educational activities, such as morbidity and mortality conferences, tumor boards, surgical planning conferences, case discussions, etc., allow fellows to gain medical knowledge directly applicable to the patients they serve. Programs should define those educational activities in which fellows are expected to participate and for which time is protected. Further specification can be found in IV.C.

600

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

603
604 IV.B. ACGME Competencies
605

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.

606
607 IV.B.1. The program must integrate the following ACGME Competencies
608 into the curriculum: (Core)

609
610 IV.B.1.a) Professionalism
611
612 Fellows must demonstrate a commitment to professionalism
613 and an adherence to ethical principles. (Core)

614
615 IV.B.1.b) Patient Care and Procedural Skills
616

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.

617
618 IV.B.1.b).(1) Fellows must be able to provide patient care that is
619 compassionate, appropriate, and effective for the
620 treatment of health problems and the promotion of
621 health. (Core)

622
623 IV.B.1.b).(1).(a) Fellows must demonstrate competence in
624 performing a female pelvic exam, including
625 quantification of pelvic organ prolapse. (Core)

626
627 IV.B.1.b).(1).(b) Fellows must demonstrate competence in the
628 evaluation and management of patients with:

629
630 IV.B.1.b).(1).(b).(i) urinary incontinence; (Core)
631

632	IV.B.1.b).(1).(b).(ii)	filling, storage, and emptying abnormalities
633		of the lower urinary tract, and resulting
634		abnormalities of the upper urinary tract; (Core)
635		
636	IV.B.1.b).(1).(b).(iii)	pelvic organ prolapse; (Core)
637		
638	IV.B.1.b).(1).(b).(iv)	genitourinary and rectovaginal fistulae; (Core)
639		
640	IV.B.1.b).(1).(b).(v)	anorectal disorders, including fecal
641		incontinence, functional anorectal pain, and
642		functional defecation disorders, such as
643		inadequate defecatory propulsion and
644		dyssynergic defecation; (Core)
645		
646	IV.B.1.b).(1).(b).(vi)	sexual dysfunction; (Core)
647		
648	IV.B.1.b).(1).(b).(vii)	urethral diverticula; (Core)
649		
650	IV.B.1.b).(1).(b).(viii)	genitourinary tract injuries; (Core)
651		
652	IV.B.1.b).(1).(b).(ix)	obstetrical injuries; (Core)
653		
654	IV.B.1.b).(1).(b).(x)	congenital anomalies; (Core)
655		
656	IV.B.1.b).(1).(b).(xi)	infectious and non-infectious irritative
657		conditions of the lower urinary tract and
658		pelvic floor; (Core)
659		
660	IV.B.1.b).(1).(b).(xii)	hematuria; (Core)
661		
662	IV.B.1.b).(1).(b).(xiii)	painful bladder, including painful bladder
663		syndrome/interstitial cystitis and pelvic pain;
664		(Core)
665		
666	IV.B.1.b).(1).(b).(xiv)	neuromuscular dysfunction of the bladder
667		and urethra; and, (Core)
668		
669	IV.B.1.b).(1).(b).(xv)	urinary tract infection. (Core)
670		
671	IV.B.1.b).(1).(c)	Fellows must demonstrate competence in peri-
672		operative evaluation and management of the
673		geriatric patient. (Core)
674		
675	IV.B.1.b).(1).(d)	Fellows must demonstrate competence in
676		assessing the effects of treatment and recognizing
677		and managing the complications of therapy. (Core)
678		
679	IV.B.1.b).(2)	Fellows must be able to perform all medical,
680		diagnostic, and surgical procedures considered
681		essential for the area of practice. (Core)
682		

683	IV.B.1.b).(2).(a)	Fellows must demonstrate competence in performance and/or interpretation of diagnostic studies, including:
684		
685		
686		
687	IV.B.1.b).(2).(a).(i)	abdominal and pelvic imaging; ^(Core)
688		
689	IV.B.1.b).(2).(a).(ii)	advanced laparoscopic, abdominal, and vaginal surgery for uterovaginal prolapse and post-hysterectomy vaginal vault prolapse, to include reconstructive and obliterative procedures. ^(Core)
690		
691		
692		
693		
694		
695	IV.B.1.b).(2).(a).(iii)	cystoscopy; ^(Core)
696		
697	IV.B.1.b).(2).(a).(iv)	tests for anorectal disorders; and, ^(Core)
698		
699	IV.B.1.b).(2).(a).(v)	urodynamic testing. ^(Core)
700		
701	IV.B.1.b).(2).(b)	Fellows must demonstrate competence in surgical procedures for patients with the conditions outlined in IV.B.1.b).(1).(b).(i)-IV.B.1.b).(1).(b).(xv). ^(Core)
702		
703		
704		
705	IV.B.1.c)	Medical Knowledge
706		
707		
708		Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. ^(Core)
709		
710		
711		
712	IV.B.1.c).(1)	Fellows must demonstrate knowledge of:
713		
714	IV.B.1.c).(1).(a)	the conditions outlined in IV.B.1.b).(1).(b).(i)-IV.B.1.b).(1).(b).(xv); ^(Core)
715		
716		
717	IV.B.1.c).(1).(b)	the epidemiology of urinary incontinence, pelvic organ prolapse, and defecation disorders, including birth, aging, and neurologic disease; ^(Core)
718		
719		
720		
721	IV.B.1.c).(1).(c)	the impact of urinary incontinence, pelvic organ prolapse, and defecation disorders on quality of life; ^(Core)
722		
723		
724		
725	IV.B.1.c).(1).(d)	the use and interpretation of disease-specific and global health questionnaires to evaluate the impact of pelvic floor disorders on quality of life; ^(Core)
726		
727		
728		
729	IV.B.1.c).(1).(e)	indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline; ^(Core)
730		
731		
732		
733		

734	IV.B.1.c).(1).(f)	the anatomy, physiology, and pathophysiology of
735		the pelvic floor, including the urinary tract, colon,
736		rectum, anus, and vagina; ^(Core)
737		
738	IV.B.1.c).(1).(g)	clinically pertinent areas of pathology, infectious
739		disease, geriatric medicine, physical therapy, pain
740		management, sexual dysfunction, and psychosocial
741		aspects of pelvic floor disorders; ^(Core)
742		
743	IV.B.1.c).(1).(h)	indications, contraindications, limitations,
744		complications, techniques, and interpretation of
745		results of screening, diagnostic, and therapeutic
746		procedures for the treatment and evaluation of
747		pelvic floor disorders, to include: ^(Core)
748		
749	IV.B.1.c).(1).(h).(i)	pelvic imaging studies for the diagnostic
750		evaluation of urinary and anal incontinence,
751		pelvic floor dysfunction, and prolapse; and,
752		^(Core)
753		
754	IV.B.1.c).(1).(h).(ii)	urodynamic assessment. ^(Core)
755		
756	IV.B.1.c).(1).(i)	assessment and treatment of lower urinary tract
757		dysfunction secondary to neurologic diseases; ^(Core)
758		
759	IV.B.1.c).(1).(j)	indications, contraindications, limitations,
760		complications, techniques, and interpretation of
761		results of screening, diagnostic, and therapeutic
762		procedures including surgery for: ^(Core)
763		
764	IV.B.1.c).(1).(j).(i)	pelvic organ prolapse; ^(Core)
765		
766	IV.B.1.c).(1).(j).(ii)	urinary incontinence; ^(Core)
767		
768	IV.B.1.c).(1).(j).(iii)	rectovaginal fistula related to obstetric
769		trauma; ^(Core)
770		
771	IV.B.1.c).(1).(j).(iv)	vesicovaginal, vesicouterine, and
772		urethrovaginal fistula; ^(Core)
773		
774	IV.B.1.c).(1).(j).(v)	urethral diverticula; ^(Core)
775		
776	IV.B.1.c).(1).(j).(vi)	congenital anomalies of the urogenital tract;
777		and, ^(Core)
778		
779	IV.B.1.c).(1).(j).(vii)	urogenital injuries. ^(Core)
780		
781	IV.B.1.c).(1).(k)	the scientific method of problem solving and
782		evidence-based decision making; and, ^(Core)
783		
784	IV.B.1.c).(1).(l)	quantitative techniques, including biostatistics,

785 epidemiology, research design, and research
786 methods. ^(Core)

787
788 **IV.B.1.d) Practice-based Learning and Improvement**

789
790 **Fellows must demonstrate the ability to investigate and**
791 **evaluate their care of patients, to appraise and assimilate**
792 **scientific evidence, and to continuously improve patient care**
793 **based on constant self-evaluation and lifelong learning.** ^(Core)
794

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.

795
796 **IV.B.1.e) Interpersonal and Communication Skills**

797
798 **Fellows must demonstrate interpersonal and communication**
799 **skills that result in the effective exchange of information and**
800 **collaboration with patients, their families, and health**
801 **professionals.** ^(Core)
802

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

804
805 **Fellows must demonstrate an awareness of and**
806 **responsiveness to the larger context and system of health**
807 **care, including the social determinants of health, as well as**
808 **the ability to call effectively on other resources to provide**
809 **optimal health care.** ^(Core)
810

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

812
813 **IV.C.1. The curriculum must be structured to optimize fellow educational**
814 **experiences, the length of these experiences, and supervisory**
815 **continuity.** ^(Core)
816

817 **IV.C.1.a)** At the beginning of the program, each fellow must be provided
818 with a written individual educational plan that includes a monthly
819 block rotation diagram displaying the clinical, didactic, and
820 research activities by rotation. ^(Core)
821

822 **IV.C.1.b)** Clinical experiences must be of sufficient length to ensure
823 continuity of patient care, ongoing supervision, longitudinal
824 relationships with faculty members, and meaningful assessment
825 and feedback. ^(Core)
826

- 827 **IV.C.2.** **The program must provide instruction and experience in pain**
828 **management if applicable for the subspecialty, including recognition**
829 **of the signs of addiction.** ^(Core)
830
- 831 **IV.C.3.** The 36-month program must include: ^(Core)
832
- 833 **IV.C.3.a)** 18 months of clinical activity; ^(Core)
834
- 835 **IV.C.3.b)** 12 months of research; and, ^(Core)
836
- 837 **IV.C.3.b).(1)** If fellows are assigned clinical duties during research
838 months, this experience must be limited to four hours per
839 week. ^(Core)
840
- 841 **IV.C.3.b).(2)** If clinical activities are in the core specialty, the clinical time
842 must be counted as independent practice as outlined in
843 IV.E.-IV.E.1.a).(2). ^(Core)
844
- 845 **IV.C.3.c)** six months of clinical activity, research, and/or elective
846 experiences consistent with the program aims and at the
847 discretion of the program director. ^(Core)
848
- 849 **IV.C.4.** The 24-month program must include: ^(Core)
850
- 851 **IV.C.4.a)** 18 months of clinical activity; and, ^(Core)
852
- 853 **IV.C.4.a).(1)** If fellows engage in research activities during this period, a
854 majority of the total time must be devoted to clinical
855 activity. ^(Core)
856
- 857 **IV.C.4.b)** six months of clinical activity, research, and/or elective
858 experiences consistent with the program aims and at the
859 discretion of the program director. ^(Core)
860
- 861 **IV.C.5.** **Fellows' clinical activities must include both inpatient and outpatient**
862 **experiences.** ^(Core)
863
- 864 **IV.C.5.a)** **Fellows should have supervised responsibility for the total care of**
865 **the patient, including initial evaluation, establishment of diagnosis,**
866 **selection of appropriate therapy, and management of**
867 **complications.** ^(Core)
868
- 869 **IV.C.5.b)** **Fellows must participate in continuity of patient care through pre-**
870 **operative and post-operative settings and inpatient contact.** ^(Core)
871
- 872 **IV.C.5.c)** **Fellows must record all surgical procedures in which they have a**
873 **significant role in the ACGME Case Log System.** ^(Core)
874
- 875 **IV.C.5.d)** ~~The total time devoted to these experiences should not exceed 24~~
876 ~~months.~~ ^(Detail)
877

- 878 IV.C.6. ~~The 12 months of the program not devoted to inpatient and outpatient~~
879 ~~experiences should be devoted to research and/or other elective~~
880 ~~experiences.~~ ^(Detail)
881
- 882 IV.C.7. Scheduled didactics, including morbidity and mortality conferences, must
883 comprise a minimum of one hour per week (averaged over four weeks),
884 pertain to material relevant to the practice of female pelvic medicine and
885 reconstructive surgery, be directed specifically to the fellows, be
886 conducted at a fellowship level, and be presented by on-site faculty
887 members a majority of the time. ^(Core)
888
- 889 IV.C.7.a) Topics must include the content outlined in IV.B.1.b).(1).(b).(i)-
890 IV.B.1.b).(1).(b).(xv). ^(Core)
891
- 892 IV.C.7.b) Morbidity and mortality conferences must take place at least once
893 per quarter. ^(Core)
894
- 895 **IV.D. Scholarship**
896
- 897 ***Medicine is both an art and a science. The physician is a humanistic***
898 ***scientist who cares for patients. This requires the ability to think critically,***
899 ***evaluate the literature, appropriately assimilate new knowledge, and***
900 ***practice lifelong learning. The program and faculty must create an***
901 ***environment that fosters the acquisition of such skills through fellow***
902 ***participation in scholarly activities as defined in the subspecialty-specific***
903 ***Program Requirements. Scholarly activities may include discovery,***
904 ***integration, application, and teaching.***
- 905
- 906 ***The ACGME recognizes the diversity of fellowships and anticipates that***
907 ***programs prepare physicians for a variety of roles, including clinicians,***
908 ***scientists, and educators. It is expected that the program's scholarship will***
909 ***reflect its mission(s) and aims, and the needs of the community it serves.***
910 ***For example, some programs may concentrate their scholarly activity on***
911 ***quality improvement, population health, and/or teaching, while other***
912 ***programs might choose to utilize more classic forms of biomedical***
913 ***research as the focus for scholarship.***
914
- 915 **IV.D.1. Program Responsibilities**
916
- 917 **IV.D.1.a) The program must demonstrate evidence of scholarly**
918 **activities, consistent with its mission(s) and aims. ^(Core)**
919
- 920 **IV.D.1.b) The program in partnership with its Sponsoring Institution,**
921 **must allocate adequate resources to facilitate fellow and**
922 **faculty involvement in scholarly activities. ^(Core)**
923
- 924 **IV.D.2. Faculty Scholarly Activity**
925
- 926 **IV.D.2.a) Among their scholarly activity, programs must demonstrate**
927 **accomplishments in at least three of the following domains:**
928 **^(Core)**

- 929
 - 930
 - 931
 - 932
 - 933
 - 934
 - 935
 - 936
 - 937
 - 938
 - 939
 - 940
 - 941
 - 942
 - 943
 - 944
 - 945
 - 946
- Research in basic science, education, translational science, patient care, or population health
 - Peer-reviewed grants
 - Quality improvement and/or patient safety initiatives
 - Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports
 - Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
 - Contribution to professional committees, educational organizations, or editorial boards
 - Innovations in education

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

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

947

948 **IV.D.2.b).(1) faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)‡**

949

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956

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

958

959 **IV.D.3. Fellow Scholarly Activity**

960

961 **IV.D.3.a) The educational program for obstetrics and gynecology graduates must include:**

962

963

964 **IV.D.3.a).(1) structured delivery of education in research design, grant writing, research methodology, scientific writing, and presentation skills; and, (Core)**

965

966

967

968 **IV.D.3.a).(2) completion and defense of a scholarly paper (thesis). (Core)**

969

970	IV.D.3.a).(2).(a)	Under the direction of a faculty mentor, each fellow must complete a comprehensive written scholarly paper (thesis) during the program that demonstrates the following: ^(Core)
971		
972		
973		
974		
975	IV.D.3.a).(2).(a).(i)	utilization of appropriate research design, methodology, and analysis; ^(Core)
976		
977		collection and analysis of information obtained from a structured basic, translational and/or clinical research setting; and, ^(Core)
978	IV.D.3.a).(2).(a).(ii)	
979		
980		
981		
982		synthesis of the scientific literature, hypothesis testing, and description of findings and results. ^(Core)
983	IV.D.3.a).(2).(a).(iii)	
984		
985		
986		Prior to completion of the fellowship, each fellow must have: ^(Core)
987	IV.D.3.a).(2).(b)	
988		
989		a thesis of such quality as to allow admittance to the American Board of Obstetrics and Gynecology or American Osteopathic Board of Obstetrics and Gynecology Certifying Examination; ^(Core)
990	IV.D.3.a).(2).(b).(i)	
991		
992		
993		
994		completed and submitted a written manuscript to the program director; and, ^(Core)
995	IV.D.3.a).(2).(b).(ii)	
996		
997		
998		defended the thesis to the program director and research mentor, and other members of the division at the discretion of the program director. ^(Core)
999		
1000	IV.D.3.a).(2).(b).(iii)	
1001		
1002		
1003		A copy of the thesis and thesis defense documentation must be available upon request. ^(Core)
1004	IV.D.3.a).(2).(c)	
1005		
1006		
1007		The educational program for urology graduates must include a scholarly manuscript or quality improvement project paper under the direction of a faculty mentor. ^(Core)
1008	IV.D.3.b)	
1009		
1010		
1011		The scholarly manuscript or quality improvement project paper must demonstrate the following: ^(Core)
1012	IV.D.3.b).(1)	
1013		
1014		utilization of appropriate research design, methodology, and analysis; ^(Core)
1015	IV.D.3.b).(1).(a)	
1016		collection and analysis of information obtained from a structured basic laboratory, translational, and/or
1017		
1018	IV.D.3.b).(1).(b)	
1019		
1020		

- 1021 clinical research setting; and, ^(Core)
- 1022
- 1023 IV.D.3.b).(1).(c) synthesis of the scientific literature, hypothesis
- 1024 testing, and description of findings and results. ^(Core)
- 1025
- 1026 IV.D.3.b).(2) Prior to completion of the fellowship, each fellow must give
- 1027 an oral presentation of the scholarly project to the program
- 1028 director, faculty mentor, other faculty members, and other
- 1029 learners. ^(Core)
- 1030
- 1031 **IV.E. Fellowship programs may assign fellows to engage in the independent**
- 1032 **practice of their core specialty during their fellowship program.**
- 1033
- 1034 **IV.E.1. If programs permit their fellows to utilize the independent practice**
- 1035 **option, it must not exceed 20 percent of their time per week or 10**
- 1036 **weeks of an academic year. ^(Core)**
- 1037
- 1038 IV.E.1.a) Female pelvic medicine and reproductive surgery programs are
- 1039 permitted to assign fellows to independent practice in their primary
- 1040 specialty, but such practice must not exceed 10 percent of a
- 1041 fellow's time per week, averaged over four weeks. ^(Core)
- 1042
- 1043 IV.E.1.a).(1) Independent practice during regular office hours must be
- 1044 limited to four hours per week, averaged over four weeks.
- 1045 ^(Core)
- 1046
- 1047 IV.E.1.a).(2) The total amount of independent practice, both during and
- 1048 outside of regular office hours, must not exceed 24 hours a
- 1049 month. ^(Core)
- 1050

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.

Specialty-Specific Background and Intent: Female pelvic medicine and reconstructive surgery must be the primary focus of a fellow's clinical practice. Independent practice must not substantially interfere with fellows' subspecialty education. Fellows who enter the female pelvic medicine and reconstructive surgery program after completing an obstetrics and gynecology program must limit independent practice to general obstetrics and gynecology. Fellows who enter the female pelvic medicine and reconstructive surgery program after completing a urology program must limit independent practice to general urology.

Regular office hours are defined as Monday through Friday, 8:00 a.m. to 5:00 p.m.

1068

1069 **V. Evaluation**

1070

1071 V.A. Fellow Evaluation
1072
1073 V.A.1. Feedback and Evaluation
1074

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

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

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

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

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

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

1075
1076 V.A.1.a) Faculty members must directly observe, evaluate, and
1077 frequently provide feedback on fellow performance during
1078 each rotation or similar educational assignment. ^(Core)
1079

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.

1080
1081 V.A.1.b) Evaluation must be documented at the completion of the
1082 assignment. ^(Core)
1083

1084 V.A.1.b).(1) For block rotations of greater than three months in
1085 duration, evaluation must be documented at least
1086 every three months. ^(Core)
1087

- 1088 V.A.1.b).(2) Longitudinal experiences such as continuity clinic in
 1089 the context of other clinical responsibilities must be
 1090 evaluated at least every three months and at
 1091 completion. ^(Core)
 1092
- 1093 V.A.1.c) The program must provide an objective performance
 1094 evaluation based on the Competencies and the subspecialty-
 1095 specific Milestones, and must: ^(Core)
 1096
- 1097 V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers,
 1098 patients, self, and other professional staff members);
 1099 and, ^(Core)
 1100
- 1101 V.A.1.c).(2) provide that information to the Clinical Competency
 1102 Committee for its synthesis of progressive fellow
 1103 performance and improvement toward unsupervised
 1104 practice. ^(Core)
 1105

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.

- 1106
- 1107 V.A.1.d) The program director or their designee, with input from the
 1108 Clinical Competency Committee, must:
 1109
- 1110 V.A.1.d).(1) meet with and review with each fellow their
 1111 documented semi-annual evaluation of performance,
 1112 including progress along the subspecialty-specific
 1113 Milestones. ^(Core)
 1114
- 1115 V.A.1.d).(2) assist fellows in developing individualized learning
 1116 plans to capitalize on their strengths and identify areas
 1117 for growth; and, ^(Core)
 1118
- 1119 V.A.1.d).(3) develop plans for fellows failing to progress, following
 1120 institutional policies and procedures. ^(Core)
 1121

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.

- 1122
1123 V.A.1.e) At least annually, there must be a summative evaluation of
1124 each fellow that includes their readiness to progress to the
1125 next year of the program, if applicable. ^(Core)
1126
- 1127 V.A.1.f) The evaluations of a fellow's performance must be accessible
1128 for review by the fellow. ^(Core)
1129
- 1130 V.A.2. Final Evaluation
1131
- 1132 V.A.2.a) The program director must provide a final evaluation for each
1133 fellow upon completion of the program. ^(Core)
1134
- 1135 V.A.2.a).(1) The subspecialty-specific Milestones, and when
1136 applicable the subspecialty-specific Case Logs, must
1137 be used as tools to ensure fellows are able to engage
1138 in autonomous practice upon completion of the
1139 program. ^(Core)
1140
- 1141 V.A.2.a).(2) The final evaluation must:
1142
- 1143 V.A.2.a).(2).(a) become part of the fellow's permanent record
1144 maintained by the institution, and must be
1145 accessible for review by the fellow in
1146 accordance with institutional policy; ^(Core)
1147
- 1148 V.A.2.a).(2).(b) verify that the fellow has demonstrated the
1149 knowledge, skills, and behaviors necessary to
1150 enter autonomous practice; ^(Core)
1151
- 1152 V.A.2.a).(2).(c) consider recommendations from the Clinical
1153 Competency Committee; and, ^(Core)
1154
- 1155 V.A.2.a).(2).(d) be shared with the fellow upon completion of
1156 the program. ^(Core)
1157
- 1158 V.A.3. A Clinical Competency Committee must be appointed by the
1159 program director. ^(Core)
1160

- 1161 V.A.3.a) At a minimum the Clinical Competency Committee must
 1162 include three members, at least one of whom is a core faculty
 1163 member. Members must be faculty members from the same
 1164 program or other programs, or other health professionals
 1165 who have extensive contact and experience with the
 1166 program's fellows. ^(Core)
 1167
- 1168 V.A.3.b) The Clinical Competency Committee must:
- 1169
- 1170 V.A.3.b).(1) review all fellow evaluations at least semi-annually;
 1171 ^(Core)
 1172
- 1173 V.A.3.b).(2) determine each fellow's progress on achievement of
 1174 the subspecialty-specific Milestones; and, ^(Core)
 1175
- 1176 V.A.3.b).(3) meet prior to the fellows' semi-annual evaluations and
 1177 advise the program director regarding each fellow's
 1178 progress. ^(Core)
 1179
- 1180 V.B. Faculty Evaluation
- 1181
- 1182 V.B.1. The program must have a process to evaluate each faculty
 1183 member's performance as it relates to the educational program at
 1184 least annually. ^(Core)
 1185

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.

- 1186
- 1187 V.B.1.a) This evaluation must include a review of the faculty member's
 1188 clinical teaching abilities, engagement with the educational
 1189 program, participation in faculty development related to their
 1190 skills as an educator, clinical performance, professionalism,
 1191 and scholarly activities. ^(Core)
 1192

- 1193 **V.B.1.b)** This evaluation must include written, confidential evaluations
 1194 by the fellows. ^(Core)
 1195
 1196 **V.B.2.** Faculty members must receive feedback on their evaluations at least
 1197 annually. ^(Core)
 1198
 1199 **V.B.3.** Results of the faculty educational evaluations should be
 1200 incorporated into program-wide faculty development plans. ^(Core)
 1201

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.

- 1202
 1203 **V.C. Program Evaluation and Improvement**
 1204
 1205 **V.C.1.** The program director must appoint the Program Evaluation
 1206 Committee to conduct and document the Annual Program
 1207 Evaluation as part of the program’s continuous improvement
 1208 process. ^(Core)
 1209
 1210 **V.C.1.a)** The Program Evaluation Committee must be composed of at
 1211 least two program faculty members, at least one of whom is a
 1212 core faculty member, and at least one fellow. ^(Core)
 1213
 1214 **V.C.1.b)** Program Evaluation Committee responsibilities must include:
 1215
 1216 **V.C.1.b).(1)** acting as an advisor to the program director, through
 1217 program oversight; ^(Core)
 1218
 1219 **V.C.1.b).(2)** review of the program’s self-determined goals and
 1220 progress toward meeting them; ^(Core)
 1221
 1222 **V.C.1.b).(3)** guiding ongoing program improvement, including
 1223 development of new goals, based upon outcomes;
 1224 and, ^(Core)
 1225
 1226 **V.C.1.b).(4)** review of the current operating environment to identify
 1227 strengths, challenges, opportunities, and threats as
 1228 related to the program’s mission and aims. ^(Core)
 1229

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.

1230

1231	V.C.1.c)	The Program Evaluation Committee should consider the
1232		following elements in its assessment of the program:
1233		
1234	V.C.1.c).(1)	curriculum; <small>(Core)</small>
1235		
1236	V.C.1.c).(2)	outcomes from prior Annual Program Evaluation(s);
1237		<small>(Core)</small>
1238		
1239	V.C.1.c).(3)	ACGME letters of notification, including citations,
1240		Areas for Improvement, and comments; <small>(Core)</small>
1241		
1242	V.C.1.c).(4)	quality and safety of patient care; <small>(Core)</small>
1243		
1244	V.C.1.c).(5)	aggregate fellow and faculty:
1245		
1246	V.C.1.c).(5).(a)	well-being; <small>(Core)</small>
1247		
1248	V.C.1.c).(5).(b)	recruitment and retention; <small>(Core)</small>
1249		
1250	V.C.1.c).(5).(c)	workforce diversity; <small>(Core)</small>
1251		
1252	V.C.1.c).(5).(d)	engagement in quality improvement and patient
1253		safety; <small>(Core)</small>
1254		
1255	V.C.1.c).(5).(e)	scholarly activity; <small>(Core)</small>
1256		
1257	V.C.1.c).(5).(f)	ACGME Resident/Fellow and Faculty Surveys
1258		(where applicable); and, <small>(Core)</small>
1259		
1260	V.C.1.c).(5).(g)	written evaluations of the program. <small>(Core)</small>
1261		
1262	V.C.1.c).(6)	aggregate fellow:
1263		
1264	V.C.1.c).(6).(a)	achievement of the Milestones; <small>(Core)</small>
1265		
1266	V.C.1.c).(6).(b)	in-training examinations (where applicable);
1267		<small>(Core)</small>
1268		
1269	V.C.1.c).(6).(c)	board pass and certification rates; and, <small>(Core)</small>
1270		
1271	V.C.1.c).(6).(d)	graduate performance. <small>(Core)</small>
1272		
1273	V.C.1.c).(7)	aggregate faculty:
1274		
1275	V.C.1.c).(7).(a)	evaluation; and, <small>(Core)</small>
1276		
1277	V.C.1.c).(7).(b)	professional development <small>(Core)</small>
1278		
1279	V.C.1.d)	The Program Evaluation Committee must evaluate the
1280		program's mission and aims, strengths, areas for
1281		improvement, and threats. <small>(Core)</small>

- 1282
 1283 **V.C.1.e)** The annual review, including the action plan, must:
 1284
 1285 **V.C.1.e).(1)** be distributed to and discussed with the members of
 1286 the teaching faculty and the fellows; and, ^(Core)
 1287
 1288 **V.C.1.e).(2)** be submitted to the DIO. ^(Core)
 1289
 1290 **V.C.2.** The program must participate in a Self-Study prior to its 10-Year
 1291 Accreditation Site Visit. ^(Core)
 1292
 1293 **V.C.2.a)** A summary of the Self-Study must be submitted to the DIO.
 1294 ^(Core)
 1295

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.

- 1296
 1297 **V.C.3.** *One goal of ACGME-accredited education is to educate physicians*
 1298 *who seek and achieve board certification. One measure of the*
 1299 *effectiveness of the educational program is the ultimate pass rate.*
 1300
 1301 *The program director should encourage all eligible program*
 1302 *graduates to take the certifying examination offered by the*
 1303 *applicable American Board of Medical Specialties (ABMS) member*
 1304 *board or American Osteopathic Association (AOA) certifying board.*
 1305
 1306 **V.C.3.a)** For subspecialties in which the ABMS member board and/or
 1307 AOA certifying board offer(s) an annual written exam, in the
 1308 preceding three years, the program's aggregate pass rate of
 1309 those taking the examination for the first time must be higher
 1310 than the bottom fifth percentile of programs in that
 1311 subspecialty. ^(Outcome)
 1312
 1313 **V.C.3.b)** For subspecialties in which the ABMS member board and/or
 1314 AOA certifying board offer(s) a biennial written exam, in the
 1315 preceding six years, the program's aggregate pass rate of
 1316 those taking the examination for the first time must be higher
 1317 than the bottom fifth percentile of programs in that
 1318 subspecialty. ^(Outcome)
 1319
 1320 **V.C.3.c)** For subspecialties in which the ABMS member board and/or
 1321 AOA certifying board offer(s) an annual oral exam, in the

1322 preceding three years, the program's aggregate pass rate of
1323 those taking the examination for the first time must be higher
1324 than the bottom fifth percentile of programs in that
1325 subspecialty. ^(Outcome)

1326
1327 **V.C.3.d)** For subspecialties in which the ABMS member board and/or
1328 AOA certifying board offer(s) a biennial oral exam, in the
1329 preceding six years, the program's aggregate pass rate of
1330 those taking the examination for the first time must be higher
1331 than the bottom fifth percentile of programs in that
1332 subspecialty. ^(Outcome)

1333
1334 **V.C.3.e)** For each of the exams referenced in V.C.3.a)-d), any program
1335 whose graduates over the time period specified in the
1336 requirement have achieved an 80 percent pass rate will have
1337 met this requirement, no matter the percentile rank of the
1338 program for pass rate in that subspecialty. ^(Outcome)

1339

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.

1340
1341 **V.C.3.f)** Programs must report, in ADS, board certification status
1342 annually for the cohort of board-eligible fellows that
1343 graduated seven years earlier. ^(Core)

1344

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.

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1346 **VI. The Learning and Working Environment**

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

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

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

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

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

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

1375 *continuous focus on the safety, individual needs, and humanity of*
1376 *their patients. It is the right of each patient to be cared for by fellows*
1377 *who are appropriately supervised; possess the requisite knowledge,*
1378 *skills, and abilities; understand the limits of their knowledge and*
1379 *experience; and seek assistance as required to provide optimal*
1380 *patient care.*

1381
1382 *Fellows must demonstrate the ability to analyze the care they*
1383 *provide, understand their roles within health care teams, and play an*
1384 *active role in system improvement processes. Graduating fellows*
1385 *will apply these skills to critique their future unsupervised practice*
1386 *and effect quality improvement measures.*

1387
1388 *It is necessary for fellows and faculty members to consistently work*
1389 *in a well-coordinated manner with other health care professionals to*
1390 *achieve organizational patient safety goals.*

1391

1392 VI.A.1.a) Patient Safety

1393

1394 VI.A.1.a).(1) Culture of Safety

1395

1396 *A culture of safety requires continuous identification*
1397 *of vulnerabilities and a willingness to transparently*
1398 *deal with them. An effective organization has formal*
1399 *mechanisms to assess the knowledge, skills, and*
1400 *attitudes of its personnel toward safety in order to*
1401 *identify areas for improvement.*

1402

1403 VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows
1404 must actively participate in patient safety
1405 systems and contribute to a culture of safety.
1406 (Core)

1407

1408 VI.A.1.a).(1).(b) The program must have a structure that
1409 promotes safe, interprofessional, team-based
1410 care. (Core)

1411

1412 VI.A.1.a).(2) Education on Patient Safety

1413

1414 Programs must provide formal educational activities
1415 that promote patient safety-related goals, tools, and
1416 techniques. (Core)

1417

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

1418

1419 VI.A.1.a).(3) Patient Safety Events

1420

1421 *Reporting, investigation, and follow-up of adverse*
1422 *events, near misses, and unsafe conditions are pivotal*
1423 *mechanisms for improving patient safety, and are*

1424 *essential for the success of any patient safety*
1425 *program. Feedback and experiential learning are*
1426 *essential to developing true competence in the ability*
1427 *to identify causes and institute sustainable systems-*
1428 *based changes to ameliorate patient safety*
1429 *vulnerabilities.*

1430
1431 **VI.A.1.a).(3).(a)** Residents, fellows, faculty members, and other
1432 clinical staff members must:

1433
1434 **VI.A.1.a).(3).(a).(i)** know their responsibilities in reporting
1435 patient safety events at the clinical site;
1436 (Core)

1437
1438 **VI.A.1.a).(3).(a).(ii)** know how to report patient safety
1439 events, including near misses, at the
1440 clinical site; and, (Core)

1441
1442 **VI.A.1.a).(3).(a).(iii)** be provided with summary information
1443 of their institution's patient safety
1444 reports. (Core)

1445
1446 **VI.A.1.a).(3).(b)** Fellows must participate as team members in
1447 real and/or simulated interprofessional clinical
1448 patient safety activities, such as root cause
1449 analyses or other activities that include
1450 analysis, as well as formulation and
1451 implementation of actions. (Core)

1452
1453 **VI.A.1.a).(4)** Fellow Education and Experience in Disclosure of
1454 Adverse Events

1455
1456 *Patient-centered care requires patients, and when*
1457 *appropriate families, to be apprised of clinical*
1458 *situations that affect them, including adverse events.*
1459 *This is an important skill for faculty physicians to*
1460 *model, and for fellows to develop and apply.*

1461
1462 **VI.A.1.a).(4).(a)** All fellows must receive training in how to
1463 disclose adverse events to patients and
1464 families. (Core)

1465
1466 **VI.A.1.a).(4).(b)** Fellows should have the opportunity to
1467 participate in the disclosure of patient safety
1468 events, real or simulated. (Detail)

1469
1470 **VI.A.1.b)** Quality Improvement

1471
1472 **VI.A.1.b).(1)** Education in Quality Improvement

1473

1474		<i>A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.</i>
1475		
1476		
1477		
1478		
1479	VI.A.1.b).(1).(a)	Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities. ^(Core)
1480		
1481		
1482		
1483	VI.A.1.b).(2)	Quality Metrics
1484		
1485		<i>Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.</i>
1486		
1487		
1488		
1489	VI.A.1.b).(2).(a)	Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. ^(Core)
1490		
1491		
1492		
1493	VI.A.1.b).(3)	Engagement in Quality Improvement Activities
1494		
1495		<i>Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.</i>
1496		
1497		
1498		
1499	VI.A.1.b).(3).(a)	Fellows must have the opportunity to participate in interprofessional quality improvement activities. ^(Core)
1500		
1501		
1502		
1503	VI.A.1.b).(3).(a).(i)	This should include activities aimed at reducing health care disparities. ^(Detail)
1504		
1505		
1506	VI.A.2.	Supervision and Accountability
1507		
1508	VI.A.2.a)	<i>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.</i>
1509		
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1516		
1517		<i>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.</i>
1518		
1519		
1520		
1521		
1522		
1523	VI.A.2.a).(1)	Each patient must have an identifiable and appropriately-credentialed and privileged attending
1524		

1525 physician (or licensed independent practitioner as
1526 specified by the applicable Review Committee) who is
1527 responsible and accountable for the patient's care.
1528 (Core)

1529
1530 VI.A.2.a).(1).(a) This information must be available to fellows,
1531 faculty members, other members of the health
1532 care team, and patients. (Core)

1533
1534 VI.A.2.a).(1).(b) Fellows and faculty members must inform each
1535 patient of their respective roles in that patient's
1536 care when providing direct patient care. (Core)

1537
1538 VI.A.2.b) *Supervision may be exercised through a variety of methods.*
1539 *For many aspects of patient care, the supervising physician*
1540 *may be a more advanced fellow. Other portions of care*
1541 *provided by the fellow can be adequately supervised by the*
1542 *appropriate availability of the supervising faculty member or*
1543 *fellow, either on site or by means of telecommunication*
1544 *technology. Some activities require the physical presence of*
1545 *the supervising faculty member. In some circumstances,*
1546 *supervision may include post-hoc review of fellow-delivered*
1547 *care with feedback.*

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

1549
1550 VI.A.2.b).(1) The program must demonstrate that the appropriate
1551 level of supervision in place for all fellows is based on
1552 each fellow's level of training and ability, as well as
1553 patient complexity and acuity. Supervision may be
1554 exercised through a variety of methods, as appropriate
1555 to the situation. (Core)

1556
1557 VI.A.2.b).(2) The program must define when physical presence of a
1558 supervising physician is required. (Core)

1559
1560 VI.A.2.c) Levels of Supervision

1561
1562 To promote appropriate fellow supervision while providing
1563 for graded authority and responsibility, the program must use
1564 the following classification of supervision: (Core)

1565
1566 VI.A.2.c).(1) Direct Supervision:

- 1567
1568 **VI.A.2.c).(1).(a)** the supervising physician is physically present
1569 with the fellow during the key portions of the
1570 patient interaction. ^(Core)
1571
- 1572 **VI.A.2.c).(2)** Indirect Supervision: the supervising physician is not
1573 providing physical or concurrent visual or audio
1574 supervision but is immediately available to the fellow
1575 for guidance and is available to provide appropriate
1576 direct supervision. ^(Core)
1577
- 1578 **VI.A.2.c).(3)** Oversight – the supervising physician is available to
1579 provide review of procedures/encounters with
1580 feedback provided after care is delivered. ^(Core)
1581
- 1582 **VI.A.2.d)** The privilege of progressive authority and responsibility,
1583 conditional independence, and a supervisory role in patient
1584 care delegated to each fellow must be assigned by the
1585 program director and faculty members. ^(Core)
1586
- 1587 **VI.A.2.d).(1)** The program director must evaluate each fellow’s
1588 abilities based on specific criteria, guided by the
1589 Milestones. ^(Core)
1590
- 1591 **VI.A.2.d).(2)** Faculty members functioning as supervising
1592 physicians must delegate portions of care to fellows
1593 based on the needs of the patient and the skills of
1594 each fellow. ^(Core)
1595
- 1596 **VI.A.2.d).(3)** Fellows should serve in a supervisory role to junior
1597 fellows and residents in recognition of their progress
1598 toward independence, based on the needs of each
1599 patient and the skills of the individual resident or
1600 fellow. ^(Detail)
1601
- 1602 **VI.A.2.e)** Programs must set guidelines for circumstances and events
1603 in which fellows must communicate with the supervising
1604 faculty member(s). ^(Core)
1605
- 1606 **VI.A.2.e).(1)** Each fellow must know the limits of their scope of
1607 authority, and the circumstances under which the
1608 fellow is permitted to act with conditional
1609 independence. ^(Outcome)
1610

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

- 1611
1612 **VI.A.2.f)** Faculty supervision assignments must be of sufficient
1613 duration to assess the knowledge and skills of each fellow

1614 and to delegate to the fellow the appropriate level of patient
1615 care authority and responsibility. ^(Core)

1616
1617 **VI.B. Professionalism**

1618
1619 **VI.B.1. Programs, in partnership with their Sponsoring Institutions, must**
1620 **educate fellows and faculty members concerning the professional**
1621 **responsibilities of physicians, including their obligation to be**
1622 **appropriately rested and fit to provide the care required by their**
1623 **patients. ^(Core)**

1624
1625 **VI.B.2. The learning objectives of the program must:**

1626
1627 **VI.B.2.a) be accomplished through an appropriate blend of supervised**
1628 **patient care responsibilities, clinical teaching, and didactic**
1629 **educational events; ^(Core)**

1630
1631 **VI.B.2.b) be accomplished without excessive reliance on fellows to**
1632 **fulfill non-physician obligations; and, ^(Core)**

1633

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.

1634
1635 **VI.B.2.c) ensure manageable patient care responsibilities. ^(Core)**

1636

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.

1637
1638 **VI.B.3. The program director, in partnership with the Sponsoring Institution,**
1639 **must provide a culture of professionalism that supports patient**
1640 **safety and personal responsibility. ^(Core)**

1641
1642 **VI.B.4. Fellows and faculty members must demonstrate an understanding**
1643 **of their personal role in the:**

1644
1645 **VI.B.4.a) provision of patient- and family-centered care; ^(Outcome)**

1646

1647 VI.B.4.b) safety and welfare of patients entrusted to their care,
1648 including the ability to report unsafe conditions and adverse
1649 events; (Outcome)
1650

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.

1651 VI.B.4.c) assurance of their fitness for work, including: (Outcome)
1652
1653

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

1654 VI.B.4.c).(1) management of their time before, during, and after
1655 clinical assignments; and, (Outcome)
1656
1657

1658 VI.B.4.c).(2) recognition of impairment, including from illness,
1659 fatigue, and substance use, in themselves, their peers,
1660 and other members of the health care team. (Outcome)
1661

1662 VI.B.4.d) commitment to lifelong learning; (Outcome)
1663

1664 VI.B.4.e) monitoring of their patient care performance improvement
1665 indicators; and, (Outcome)
1666

1667 VI.B.4.f) accurate reporting of clinical and educational work hours,
1668 patient outcomes, and clinical experience data. (Outcome)
1669

1670 VI.B.5. All fellows and faculty members must demonstrate responsiveness
1671 to patient needs that supersedes self-interest. This includes the
1672 recognition that under certain circumstances, the best interests of
1673 the patient may be served by transitioning that patient's care to
1674 another qualified and rested provider. (Outcome)
1675

1676 VI.B.6. Programs, in partnership with their Sponsoring Institutions, must
1677 provide a professional, equitable, respectful, and civil environment
1678 that is free from discrimination, sexual and other forms of
1679 harassment, mistreatment, abuse, or coercion of students, fellows,
1680 faculty, and staff. (Core)
1681

1682 VI.B.7. Programs, in partnership with their Sponsoring Institutions, should
1683 have a process for education of fellows and faculty regarding
1684 unprofessional behavior and a confidential process for reporting,
1685 investigating, and addressing such concerns. (Core)
1686

1687 VI.C. Well-Being

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Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of fellowship training.

Fellows and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. For example, a culture which encourages covering for colleagues after an illness without the expectation of reciprocity reflects the ideal of professionalism. A positive culture in a clinical learning environment models constructive behaviors, and prepares fellows with the skills and attitudes needed to thrive throughout their careers.

Background and Intent: The ACGME is committed to addressing physician well-being for individuals and as it relates to the learning and working environment. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians' ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and collaboration. Information regarding the ACGME's ongoing efforts in this area is available on the ACGME website.

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

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

1725

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

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

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

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

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

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

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance 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>).

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

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.

- 1756
1757 VI.C.1.e).(2) provide access to appropriate tools for self-screening;
1758 and, (Core)
1759
1760 VI.C.1.e).(3) provide access to confidential, affordable mental
1761 health assessment, counseling, and treatment,
1762 including access to urgent and emergent care 24
1763 hours a day, seven days a week. (Core)
1764

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.

- 1765
1766 VI.C.2. There are circumstances in which fellows may be unable to attend
1767 work, including but not limited to fatigue, illness, family
1768 emergencies, and parental leave. Each program must allow an
1769 appropriate length of absence for fellows unable to perform their
1770 patient care responsibilities. (Core)
1771
1772 VI.C.2.a) The program must have policies and procedures in place to
1773 ensure coverage of patient care. (Core)
1774
1775 VI.C.2.b) These policies must be implemented without fear of negative
1776 consequences for the fellow who is or was unable to provide
1777 the clinical work. (Core)
1778

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.

- 1779
 1780 **VI.D. Fatigue Mitigation**
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 1782 **VI.D.1. Programs must:**
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 1784 **VI.D.1.a) educate all faculty members and fellows to recognize the**
 1785 **signs of fatigue and sleep deprivation; ^(Core)**
 1786
 1787 **VI.D.1.b) educate all faculty members and fellows in alertness**
 1788 **management and fatigue mitigation processes; and, ^(Core)**
 1789
 1790 **VI.D.1.c) encourage fellows to use fatigue mitigation processes to**
 1791 **manage the potential negative effects of fatigue on patient**
 1792 **care and learning. ^(Detail)**
 1793

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.

- 1794
 1795 **VI.D.2. Each program must ensure continuity of patient care, consistent**
 1796 **with the program’s policies and procedures referenced in VI.C.2–**
 1797 **VI.C.2.b), in the event that a fellow may be unable to perform their**
 1798 **patient care responsibilities due to excessive fatigue. ^(Core)**
 1799
 1800 **VI.D.3. The program, in partnership with its Sponsoring Institution, must**
 1801 **ensure adequate sleep facilities and safe transportation options for**
 1802 **fellows who may be too fatigued to safely return home. ^(Core)**
 1803
 1804 **VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care**
 1805
 1806 **VI.E.1. Clinical Responsibilities**
 1807
 1808 **The clinical responsibilities for each fellow must be based on PGY**
 1809 **level, patient safety, fellow ability, severity and complexity of patient**
 1810 **illness/condition, and available support services. ^(Core)**
 1811

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.

- 1812
1813 **VI.E.2. Teamwork**
1814
1815 **Fellows must care for patients in an environment that maximizes**
1816 **communication. This must include the opportunity to work as a**
1817 **member of effective interprofessional teams that are appropriate to**
1818 **the delivery of care in the subspecialty and larger health system.**
1819 (Core)
1820
1821 VI.E.2.a) To maintain interprofessional collaboration, physicians from other
1822 specialties such as colorectal surgery and gastroenterology,
1823 credentialed registered nurses (RNs), certified nurses, certified
1824 nurse specialists (CNSs), certified dietitians, mental health
1825 providers, nurse practitioners (NPs), other advanced practice
1826 nurses, other advanced practice providers, pharmacists, physical
1827 and occupational therapists, physician assistants (PAs) and social
1828 workers should be integrated into both the didactic and clinical
1829 experience of the fellow as clinically relevant. (Detail)
1830
1831 **VI.E.3. Transitions of Care**
1832
1833 **VI.E.3.a) Programs must design clinical assignments to optimize**
1834 **transitions in patient care, including their safety, frequency,**
1835 **and structure. (Core)**
1836
1837 **VI.E.3.b) Programs, in partnership with their Sponsoring Institutions,**
1838 **must ensure and monitor effective, structured hand-over**
1839 **processes to facilitate both continuity of care and patient**
1840 **safety. (Core)**
1841
1842 **VI.E.3.c) Programs must ensure that fellows are competent in**
1843 **communicating with team members in the hand-over process.**
1844 (Outcome)
1845
1846 **VI.E.3.d) Programs and clinical sites must maintain and communicate**
1847 **schedules of attending physicians and fellows currently**
1848 **responsible for care. (Core)**
1849
1850 **VI.E.3.e) Each program must ensure continuity of patient care,**
1851 **consistent with the program's policies and procedures**
1852 **referenced in VI.C.2-VI.C.2.b), in the event that a fellow may**
1853 **be unable to perform their patient care responsibilities due to**
1854 **excessive fatigue or illness, or family emergency. (Core)**
1855
1856 **VI.F. Clinical Experience and Education**

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

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.

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

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

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

Scheduling

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

Oversight

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

Work from Home

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

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

- 1871
- 1872 **VI.F.2. Mandatory Time Free of Clinical Work and Education**
- 1873
- 1874 **VI.F.2.a) The program must design an effective program structure that**
- 1875 **is configured to provide fellows with educational**
- 1876 **opportunities, as well as reasonable opportunities for rest**
- 1877 **and personal well-being. ^(Core)**
- 1878
- 1879 **VI.F.2.b) Fellows should have eight hours off between scheduled**
- 1880 **clinical work and education periods. ^(Detail)**
- 1881
- 1882 **VI.F.2.b).(1) There may be circumstances when fellows choose to**
- 1883 **stay to care for their patients or return to the hospital**
- 1884 **with fewer than eight hours free of clinical experience**
- 1885 **and education. This must occur within the context of**
- 1886 **the 80-hour and the one-day-off-in-seven**
- 1887 **requirements. ^(Detail)**
- 1888

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

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

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

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

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

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

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

VI.F.3.a).(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or fellow education. (Core)

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

1913

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

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

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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:

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

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

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

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

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1932

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

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

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

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

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1947 VI.F.4.c).(2) Prior to submitting the request to the Review
1948 Committee, the program director must obtain approval
1949 from the Sponsoring Institution's GMEC and DIO. (Core)
1950

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.

1951
1952 VI.F.5. Moonlighting
1953
1954 VI.F.5.a) Moonlighting must not interfere with the ability of the fellow
1955 to achieve the goals and objectives of the educational
1956 program, and must not interfere with the fellow's fitness for
1957 work nor compromise patient safety. (Core)
1958
1959 VI.F.5.b) Time spent by fellows in internal and external moonlighting
1960 (as defined in the ACGME Glossary of Terms) must be
1961 counted toward the 80-hour maximum weekly limit. (Core)
1962

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>).

1963
1964 VI.F.6. In-House Night Float
1965
1966 Night float must occur within the context of the 80-hour and one-
1967 day-off-in-seven requirements. (Core)
1968

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.

1969
1970 VI.F.7. Maximum In-House On-Call Frequency
1971
1972 Fellows must be scheduled for in-house call no more frequently than
1973 every third night (when averaged over a four-week period). (Core)
1974
1975 VI.F.8. At-Home Call
1976
1977 VI.F.8.a) Time spent on patient care activities by fellows on at-home
1978 call must count toward the 80-hour maximum weekly limit.
1979 The frequency of at-home call is not subject to the every-
1980 third-night limitation, but must satisfy the requirement for one
1981 day in seven free of clinical work and education, when
1982 averaged over four weeks. (Core)

- 1983
- 1984 VI.F.8.a).(1) At-home call must not be so frequent or taxing as to
- 1985 preclude rest or reasonable personal time for each
- 1986 fellow. ^(Core)
- 1987
- 1988 VI.F.8.b) Fellows are permitted to return to the hospital while on at-
- 1989 home call to provide direct care for new or established
- 1990 patients. These hours of inpatient patient care must be
- 1991 included in the 80-hour maximum weekly limit. ^(Detail)
- 1992

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

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

- 1993
- 1994 ***
- 1995
- 1996 ***Core Requirements:** Statements that define structure, resource, or process elements
- 1997 essential to every graduate medical educational program.
- 1998
- 1999 **†Detail Requirements:** Statements that describe a specific structure, resource, or process, for
- 2000 achieving compliance with a Core Requirement. Programs and sponsoring institutions in
- 2001 substantial compliance with the Outcome Requirements may utilize alternative or innovative
- 2002 approaches to meet Core Requirements.
- 2003
- 2004 **‡Outcome Requirements:** Statements that specify expected measurable or observable
- 2005 attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their
- 2006 graduate medical education.
- 2007
- 2008 **Osteopathic Recognition**
- 2009 For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition
- 2010 Requirements also apply (www.acgme.org/OsteopathicRecognition).