Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
Int.A.	**Definition of Graduate Medical Education** ***Fellowship is advanced graduate medical education beyond a core residency program for physicians who desire to enter more specialized practice. Fellowship-trained physicians serve the public by providing subspecialty care, which may also include core medical care, acting as a community resource for expertise in their field, creating and integrating new knowledge into practice, and educating future generations of physicians. Graduate medical education values the strength that a diverse group of physicians brings to medical care, and the importance of inclusive and psychologically safe learning environments.*** ***Fellows who have completed residency are able to practice autonomously in their core specialty. The prior medical experience and expertise of fellows distinguish them from physicians entering residency. The fellow's care of patients within the subspecialty is undertaken with appropriate faculty supervision and conditional independence. Faculty members serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship. The fellow develops deep medical knowledge, patient care skills, and expertise applicable to their focused area of practice. Fellowship is an intensive program of subspecialty clinical and didactic education that focuses on the multidisciplinary care of patients. Fellowship education is often physically, emotionally, and intellectually demanding, and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.***	[None]	***Definition of Graduate Medical Education*** ***Fellowship is advanced graduate medical education beyond a core residency program for physicians who desire to enter more specialized practice. Fellowship-trained physicians serve the public by providing subspecialty care, which may also include core medical care, acting as a community resource for expertise in their field, creating and integrating new knowledge into practice, and educating future generations of physicians. Graduate medical education values the strength that a diverse group of physicians brings to medical care, and the importance of inclusive and psychologically safe learning environments.*** ***Fellows who have completed residency are able to practice autonomously in their core specialty. The prior medical experience and expertise of fellows distinguish them from physicians entering residency. The fellow's care of patients within the subspecialty is undertaken with appropriate faculty supervision and conditional independence. Faculty members serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship. The fellow develops deep medical knowledge, patient care skills, and expertise applicable to their focused area of practice. Fellowship is an intensive program of subspecialty clinical and didactic education that focuses on the multidisciplinary care of patients. Fellowship education is often physically, emotionally, and intellectually demanding, and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.***
Int.A. - (Continued)	***In addition to clinical education, many fellowship programs advance fellows' skills as physician-scientists. While the ability to create new knowledge within medicine is not exclusive to fellowship-educated physicians, the fellowship experience expands a physician's abilities to pursue hypothesis-driven scientific inquiry that results in contributions to the medical literature and patient care. Beyond the clinical subspecialty expertise achieved, fellows develop mentored relationships built on an infrastructure that promotes collaborative research.***	[None] - (Continued)	***In addition to clinical education, many fellowship programs advance fellows' skills as physician-scientists. While the ability to create new knowledge within medicine is not exclusive to fellowship-educated physicians, the fellowship experience expands a physician's abilities to pursue hypothesis-driven scientific inquiry that results in contributions to the medical literature and patient care. Beyond the clinical subspecialty expertise achieved, fellows develop mentored relationships built on an infrastructure that promotes collaborative research.***

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
Int.B.	**Definition of Subspecialty** The subspecialty of hospice and palliative medicine represents the medical component of the broad therapeutic model known as palliative care. These subspecialists seek to reduce the burden of serious illness by supporting the best quality of life throughout the course of a disease, and by managing factors that contribute to the suffering of the patient and the patient's family.	**[None]**	**Definition of Subspecialty** *The subspecialty of hospice and palliative medicine represents the medical component of the broad therapeutic model known as palliative care. These subspecialists seek to reduce the burden of serious illness by supporting the best quality of life throughout the course of a disease, and by managing factors that contribute to the suffering of the patient and the patient's family.* *Palliative care addresses physical, psychological, social, and spiritual needs of patients and their families, and provides assistance with medical decision-making.* *The major clinical skills central to the subspecialty of hospice and palliative medicine are* *the prevention (when possible), assessment and management of physical, psychological, and spiritual suffering faced by patients with serious illness and their families.* *Hospice and palliative medicine is distinguished from other disciplines by:* • *a high level of expertise in addressing the multi-dimensional needs of patients with serious illnesses, including skills in symptom-control interventions;* • *a high level of expertise in both clinical and non-clinical issues related to serious illness, the dying process, and bereavement;* • *a commitment to an interdisciplinary team approach; and,* • *a focus on the patient and family as the unit of care.*
Int.B.1.	Palliative care addresses physical, psychological, social, and spiritual needs of patients and their families, and provides assistance with medical decision making.	**[None]**	**Definition of Subspecialty** *The subspecialty of hospice and palliative medicine represents the medical component of the broad therapeutic model known as palliative care. These subspecialists seek to reduce the burden of serious illness by supporting the best quality of life throughout the course of a disease, and by managing factors that contribute to the suffering of the patient and the patient's family.* *Palliative care addresses physical, psychological, social, and spiritual needs of patients and their families, and provides assistance with medical decision-making.* *The major clinical skills central to the subspecialty of hospice and palliative medicine are* *the prevention (when possible), assessment and management of physical, psychological, and spiritual suffering faced by patients with serious illness and their families.* *Hospice and palliative medicine is distinguished from other disciplines by:* • *a high level of expertise in addressing the multi-dimensional needs of patients with serious illnesses, including skills in symptom-control interventions;* • *a high level of expertise in both clinical and non-clinical issues related to serious illness, the dying process, and bereavement;* • *a commitment to an interdisciplinary team approach; and,* • *a focus on the patient and family as the unit of care.*

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
Int.B.2.	The major clinical skills central to the subspecialty of hospice and palliative medicine are the prevention (when possible), assessment, and management of physical, psychological, and spiritual suffering faced by patients with serious illness and their families.	**[None]**	**Definition of Subspecialty** *The subspecialty of hospice and palliative medicine represents the medical component of the broad therapeutic model known as palliative care. These subspecialists seek to reduce the burden of serious illness by supporting the best quality of life throughout the course of a disease, and by managing factors that contribute to the suffering of the patient and the patient's family.* *Palliative care addresses physical, psychological, social, and spiritual needs of patients and their families, and provides assistance with medical decision-making.* *The major clinical skills central to the subspecialty of hospice and palliative medicine are* *the prevention (when possible), assessment and management of physical, psychological, and spiritual suffering faced by patients with serious illness and their families.* *Hospice and palliative medicine is distinguished from other disciplines by:* • *a high level of expertise in addressing the multi-dimensional needs of patients with serious illnesses, including skills in symptom-control interventions;* • *a high level of expertise in both clinical and non-clinical issues related to serious illness, the dying process, and bereavement;* • *a commitment to an interdisciplinary team approach; and,* • *a focus on the patient and family as the unit of care.*
Int.B.3.	Hospice and palliative medicine is distinguished from other disciplines by:	**[None]**	**Definition of Subspecialty** *The subspecialty of hospice and palliative medicine represents the medical component of the broad therapeutic model known as palliative care. These subspecialists seek to reduce the burden of serious illness by supporting the best quality of life throughout the course of a disease, and by managing factors that contribute to the suffering of the patient and the patient's family.* *Palliative care addresses physical, psychological, social, and spiritual needs of patients and their families, and provides assistance with medical decision-making.* *The major clinical skills central to the subspecialty of hospice and palliative medicine are* *the prevention (when possible), assessment and management of physical, psychological, and spiritual suffering faced by patients with serious illness and their families.* *Hospice and palliative medicine is distinguished from other disciplines by:* • *a high level of expertise in addressing the multi-dimensional needs of patients with serious illnesses, including skills in symptom-control interventions;* • *a high level of expertise in both clinical and non-clinical issues related to serious illness, the dying process, and bereavement;* • *a commitment to an interdisciplinary team approach; and,* • *a focus on the patient and family as the unit of care.*

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
Int.B.3.a)	a high level of expertise in addressing the multi-dimensional needs of patients with serious illnesses, including skills in symptom-control interventions;	**[None]**	**Definition of Subspecialty** *The subspecialty of hospice and palliative medicine represents the medical component of the broad therapeutic model known as palliative care. These subspecialists seek to reduce the burden of serious illness by supporting the best quality of life throughout the course of a disease, and by managing factors that contribute to the suffering of the patient and the patient's family.* *Palliative care addresses physical, psychological, social, and spiritual needs of patients and their families, and provides assistance with medical decision-making.* *The major clinical skills central to the subspecialty of hospice and palliative medicine are* *the prevention (when possible), assessment and management of physical, psychological, and spiritual suffering faced by patients with serious illness and their families.* *Hospice and palliative medicine is distinguished from other disciplines by:* • *a high level of expertise in addressing the multi-dimensional needs of patients with serious illnesses, including skills in symptom-control interventions;* • *a high level of expertise in both clinical and non-clinical issues related to serious illness, the dying process, and bereavement;* • *a commitment to an interdisciplinary team approach; and,* • *a focus on the patient and family as the unit of care.*
Int.B.3.b)	a high level of expertise in both clinical and non-clinical issues related to serious illness, the dying process, and bereavement;	**[None]**	**Definition of Subspecialty** *The subspecialty of hospice and palliative medicine represents the medical component of the broad therapeutic model known as palliative care. These subspecialists seek to reduce the burden of serious illness by supporting the best quality of life throughout the course of a disease, and by managing factors that contribute to the suffering of the patient and the patient's family.* *Palliative care addresses physical, psychological, social, and spiritual needs of patients and their families, and provides assistance with medical decision-making.* *The major clinical skills central to the subspecialty of hospice and palliative medicine are* *the prevention (when possible), assessment and management of physical, psychological, and spiritual suffering faced by patients with serious illness and their families.* *Hospice and palliative medicine is distinguished from other disciplines by:* • *a high level of expertise in addressing the multi-dimensional needs of patients with serious illnesses, including skills in symptom-control interventions;* • *a high level of expertise in both clinical and non-clinical issues related to serious illness, the dying process, and bereavement;* • *a commitment to an interdisciplinary team approach; and,* • *a focus on the patient and family as the unit of care.*

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Int.B.3.c)	a commitment to an interdisciplinary team approach; and,	**[None]**	**Definition of Subspecialty** *The subspecialty of hospice and palliative medicine represents the medical component of the broad therapeutic model known as palliative care. These subspecialists seek to reduce the burden of serious illness by supporting the best quality of life throughout the course of a disease, and by managing factors that contribute to the suffering of the patient and the patient's family.* *Palliative care addresses physical, psychological, social, and spiritual needs of patients and their families, and provides assistance with medical decision-making.* *The major clinical skills central to the subspecialty of hospice and palliative medicine are* *the prevention (when possible), assessment and management of physical, psychological, and spiritual suffering faced by patients with serious illness and their families.* *Hospice and palliative medicine is distinguished from other disciplines by:* • *a high level of expertise in addressing the multi-dimensional needs of patients with serious illnesses, including skills in symptom-control interventions;* • *a high level of expertise in both clinical and non-clinical issues related to serious illness, the dying process, and bereavement;* • *a commitment to an interdisciplinary team approach; and,* • *a focus on the patient and family as the unit of care.*
Int.B.3.d)	a focus on the patient and family as the unit of care.	**[None]**	**Definition of Subspecialty** *The subspecialty of hospice and palliative medicine represents the medical component of the broad therapeutic model known as palliative care. These subspecialists seek to reduce the burden of serious illness by supporting the best quality of life throughout the course of a disease, and by managing factors that contribute to the suffering of the patient and the patient's family.* *Palliative care addresses physical, psychological, social, and spiritual needs of patients and their families, and provides assistance with medical decision-making.* *The major clinical skills central to the subspecialty of hospice and palliative medicine are* *the prevention (when possible), assessment and management of physical, psychological, and spiritual suffering faced by patients with serious illness and their families.* *Hospice and palliative medicine is distinguished from other disciplines by:* • *a high level of expertise in addressing the multi-dimensional needs of patients with serious illnesses, including skills in symptom-control interventions;* • *a high level of expertise in both clinical and non-clinical issues related to serious illness, the dying process, and bereavement;* • *a commitment to an interdisciplinary team approach; and,* • *a focus on the patient and family as the unit of care.*
Int.C.	The educational program in hospice and palliative medicine must be 12 months in length. (Core)	**4.1.**	**Length of Educational Program** A fellowship program in hospice and palliative medicine must consist of 12 months of education in the subspecialty. (Core)
I.	**Oversight**	**Section 1**	**Section 1: Oversight**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
I.A.	~~Sponsoring Institution~~ ***The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education consistent with the ACGME Institutional Requirements.*** ***When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.***	[None]	***Sponsoring Institution*** ***The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education consistent with the ACGME Institutional Requirements.*** ***When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.***
I.A.1.	**The program must be sponsored by one ACGME-accredited Sponsoring**	**1.1.**	**Institution. (Core)**
I.B.	**Participating Sites** ***A participating site is an organization providing educational experiences or educational assignments/rotations for fellows.***	[None]	***Participating Sites*** ***A participating site is an organization providing educational experiences or educational assignments/rotations for fellows.***
I.B.1.	**The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)**	**1.2.**	**The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)**
I.B.1.a)	A hospice and palliative medicine program will be accredited only if the Sponsoring Institution also sponsors an ACGME-accredited program in at least one of the following specialties: anesthesiology, family medicine, internal medicine, pediatrics, psychiatry, or radiation oncology. (Core)	1.2.a.	A hospice and palliative medicine program will be accredited only if the Sponsoring Institution also sponsors an ACGME-accredited program in at least one of the following specialties: anesthesiology, family medicine, internal medicine, pediatrics, psychiatry, or radiation oncology. (Core)
I.B.2.	**There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)**	**1.3.**	**There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)**
I.B.2.a)	**The PLA must:**	**[None]**	
I.B.2.a).(1)	**be renewed at least every 10 years; and, (Core)**	**1.3.a.**	**The PLA must be renewed at least every 10 years. (Core)**
I.B.2.a).(2)	**be approved by the designated institutional official (DIO). (Core)**	**1.3.b.**	**(Core)**
I.B.3.	**The program must monitor the clinical learning and working environment at all participating sites. (Core)**	**1.4.**	**The program must monitor the clinical learning and working environment at all participating sites. (Core)**
I.B.3.a)	**At each participating site there must be one faculty member, designated by the program director, who is accountable for fellow education for that site, in collaboration with the program director. (Core)**	**1.5.**	**At each participating site there must be one faculty member, designated by the program director, who is accountable for fellow education for that site, in collaboration with the program director. (Core)**
I.B.4.	**The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core)**	**1.6.**	**The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core)**
I.B.5.	The program should ensure that fellows are not unduly burdened by required rotations at geographically distant sites. (Core)	1.6.a.	The program should ensure that fellows are not unduly burdened by required rotations at geographically distant sites. (Core)
I.C.	**The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents (if present), fellows, faculty members, senior administrative GME staff members, and other relevant members of its academic community. (Core)**	**1.7.**	**Workforce Recruitment and Retention** **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 GME staff members, and other relevant members of its academic community. (Core)**
I.D.	**Resources**	**1.8.**	**Resources** **The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for fellow education. (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
I.D.1.	**The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for fellow education. (Core)**	**1.8.**	**Resources** **The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for fellow education. (Core)**
I.D.1.a)	Facilities/Participating Sites	1.8.a.	Facilities/Participating Sites The program's participating sites must include at least four types of locations, including inpatient acute care, long-term care, home visits, and ambulatory practice settings. (Core)
I.D.1.a).(1)	The program's participating sites must include at least four types of locations, including inpatient acute care, long-term care, home visits, and ambulatory practice settings. (Core)	1.8.a.	Facilities/Participating Sites The program's participating sites must include at least four types of locations, including inpatient acute care, long-term care, home visits, and ambulatory practice settings. (Core)
I.D.1.a).(1).(a)	Hospice visits provided in these locations of care should be provided through a Medicare-certified or Veterans Administration (VA) program. (Detail)	1.8.a.1.	Hospice visits provided in these locations of care should be provided through a Medicare-certified or Veterans Administration (VA) program. (Detail)
I.D.1.b)	Patient Population The program must ensure that fellows have access to a patient population adequate to meet the needs of the fellowship. The population must represent a broad range of diagnoses and palliative care needs, including patients with advanced conditions. (Core)	1.8.b.	Patient Population The program must ensure that fellows have access to a patient population adequate to meet the needs of the fellowship. The population must represent a broad range of diagnoses and palliative care needs, including patients with advanced conditions. (Core)
I.D.1.b).(1)	The patient population should include patients of all ages, including the full pediatric age range (neonatal through adolescent/young adult). (Detail)	1.8.b.1.	The patient population should include patients of all ages, including the full pediatric age range (neonatal through adolescent/young adult). (Detail)
I.D.1.b).(2)	The patient population should include children with chronic conditions and children with palliative care needs who may recover. (Detail)	1.8.b.2.	The patient population should include children with chronic conditions and children with palliative care needs who may recover. (Detail)
I.D.1.b).(3)	The patient population should include individuals of diverse socioeconomic and cultural backgrounds. (Detail)	1.8.b.3.	The patient population should include individuals of diverse socioeconomic and cultural backgrounds. (Detail)
I.D.2.	**healthy and safe learning and working environments that promote fellow well-being and provide for:**	**1.9.**	**healthy and safe learning and working environments that promote fellow well-being and provide for:**
I.D.2.a)	**access to food while on duty; (Core)**	**1.9.a.**	**access to food while on duty; (Core)**
I.D.2.b)	**for fellows with proximity appropriate for safe patient care, if the fellows are assigned in-house call; (Core)**	**1.9.b.**	**for fellows with proximity appropriate for safe patient care, if the fellows are assigned in-house call; (Core)**
I.D.2.c)	**clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)**	**1.9.c.**	**clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)**
I.D.2.d)	**(Core)**	**1.9.d.**	**(Core)**
I.D.2.e)	**accommodations for fellows with disabilities consistent with the Sponsoring Institution's policy. (Core)**	**1.9.e.**	**accommodations for fellows with disabilities consistent with the Sponsoring Institution's policy. (Core)**
I.D.3.	**appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)**	**1.10.**	**appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)**
I.E.	**Other Learners and Health Care Personnel** **The presence of other learners and health care personnel, including but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed fellows' education. (Core)**	**1.11.**	**Other Learners and Health Care Personnel** **The presence of other learners and health care personnel, including but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed fellows' education. (Core)**
II.	**Personnel**	**Section 2**	**Section 2: Personnel**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
II.A.	**Program Director**	**2.1.**	**Program Director** **There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)**
II.A.1.	**There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)**	**2.1.**	**Program Director** **There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)**
II.A.1.a)	**The Sponsoring Institution's Graduate Medical Education Committee (GMEC) must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core)**	**2.2.**	**The Sponsoring Institution's Graduate Medical Education Committee (GMEC) must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core)**
II.A.2.	**The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)**	**2.3.**	**The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)**
II.A.2.a)	At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program: (Core) Number of Approved Fellow Positions: <7 | Minimum Support Required (FTE): 0.20 Number of Approved Fellow Positions: 7-9 | Minimum Support Required (FTE): 0.25 Number of Approved Fellow Positions: 10-12 | Minimum Support Required (FTE): 0.30 Number of Approved Fellow Positions: 13-15 | Minimum Support Required (FTE): 0.35 Number of Approved Fellow Positions: 16-18 | Minimum Support Required (FTE): 0.40 Number of Approved Fellow Positions: >18 | Minimum Support Required (FTE): 0.45	2.3.a.	At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program: (Core) Number of Approved Fellow Positions: <7 | Minimum Support Required (FTE): 0.20 Number of Approved Fellow Positions: 7-9 | Minimum Support Required (FTE): 0.25 Number of Approved Fellow Positions: 10-12 | Minimum Support Required (FTE): 0.30 Number of Approved Fellow Positions: 13-15 | Minimum Support Required (FTE): 0.35 Number of Approved Fellow Positions: 16-18 | Minimum Support Required (FTE): 0.40 Number of Approved Fellow Positions: >18 | Minimum Support Required (FTE): 0.45

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
II.A.2.b)	Programs must appoint at least one of the subspecialty-certified core faculty members to be associate program director(s). The associate program director(s) must be provided with support equal to a dedicated minimum time for administration of the program as follows: (Core) Number of Approved Fellow Positions: <7 | Minimum Aggregate Support Required (FTE): Refer to PR II.B.4.e) Number of Approved Fellow Positions: 7-9 | Minimum Aggregate Support Required (FTE): 0.13 Number of Approved Fellow Positions: 10-12 | Minimum Aggregate Support Required (FTE): 0.14 Number of Approved Fellow Positions: 13-15 | Minimum Aggregate Support Required (FTE): 0.15 Number of Approved Fellow Positions: 16-18 | Minimum Aggregate Support Required (FTE): 0.16 Number of Approved Fellow Positions: >18 | Minimum Aggregate Support Required (FTE): 0.17	2.3.b.	Programs must appoint at least one of the subspecialty-certified core faculty members to be associate program director(s). The associate program director(s) must be provided with support equal to a dedicated minimum time for administration of the program as follows: (Core) Number of Approved Fellow Positions: <7 | Minimum Aggregate Support Required (FTE): Refer to PR 2.10.e. Number of Approved Fellow Positions: 7-9 | Minimum Aggregate Support Required (FTE): 0.13 Number of Approved Fellow Positions: 10-12 | Minimum Aggregate Support Required (FTE): 0.14 Number of Approved Fellow Positions: 13-15 | Minimum Aggregate Support Required (FTE): 0.15 Number of Approved Fellow Positions: 16-18 | Minimum Aggregate Support Required (FTE): 0.16 Number of Approved Fellow Positions: >18 | Minimum Aggregate Support Required (FTE): 0.17
II.A.3.	**Qualifications of the program director:**	**2.4.**	**Qualifications of the Program Director** **The program director must possess subspecialty expertise and qualifications acceptable to the Review Committee. (Core)**
II.A.3.a)	**must include subspecialty expertise and qualifications acceptable to the Review Committee; and, (Core)**	**2.4.**	**Qualifications of the Program Director** **The program director must possess subspecialty expertise and qualifications acceptable to the Review Committee. (Core)**
II.A.3.a).(1)	The program director must have an active clinical practice in hospice and palliative medicine. (Core)	2.4.b.	The program director must have an active clinical practice in hospice and palliative medicine. (Core)
II.A.3.a).(2)	The program director must have a record of involvement in education and scholarly activities, which includes mentoring fellows (i.e., guiding fellows in the acquisition of competence in the clinical, teaching, research and advocacy skills pertinent to the discipline), serving as a clinical supervisor in an inpatient or outpatient setting, developing curricula, and/or participating in didactic activities. (Core)	2.4.c.	The program director must have a record of involvement in education and scholarly activities, which includes mentoring fellows (i.e., guiding fellows in the acquisition of competence in the clinical, teaching, research and advocacy skills pertinent to the discipline), serving as a clinical supervisor in an inpatient or outpatient setting, developing curricula, and/or participating in didactic activities. (Core)
II.A.3.a).(3)	The program director must have served a minimum of two years in a clinical practice of hospice and palliative medicine. (Core)	2.4.d.	The program director must have served a minimum of two years in a clinical practice of hospice and palliative medicine. (Core)
II.A.3.a).(4)	The program director must have at least two years of documented educational and/or administrative experience in an ACGME-accredited hospice and palliative medicine program. (Core)	2.4.e.	The program director must have at least two years of documented educational and/or administrative experience in an ACGME-accredited hospice and palliative medicine program. (Core)
II.A.3.b)	**must include current certification in the subspecialty for which they are the program director by the American Board of** Anesthesiology, Emergency Medicine, Family Medicine, Internal Medicine, Obstetrics and Gynecology, Pediatrics, Physical Medicine and Rehabilitation, Psychiatry and Neurology, Radiology, or Surgery **or by a certifying board of the American Osteopathic Association, or subspecialty qualifications that are acceptable to the Review Committee. (Core)**	**2.4.a.**	**The program director must possess current certification in the subspecialty for which they are the program director by the American Board of** Anesthesiology, Emergency Medicine, Family Medicine, Internal Medicine, Obstetrics and Gynecology, Pediatrics, Physical Medicine and Rehabilitation, Psychiatry and Neurology, Radiology, or Surgery **or by a certifying board of the American Osteopathic Association, or subspecialty qualifications that are acceptable to the Review Committee. (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
II.A.4.	The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; fellow recruitment and selection, evaluation, and promotion of fellows, and disciplinary action; supervision of fellows; and fellow education in the context of patient care. (Core)	2.5.	Program Director Responsibilities The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; fellow recruitment and selection, evaluation, and promotion of fellows, and disciplinary action; supervision of fellows; and fellow education in the context of patient care. (Core)
II.A.4.a)	The program director must:	[None]	
II.A.4.a).(1)	be a role model of professionalism; (Core)	2.5.a.	The program director must be a role model of professionalism. (Core)
II.A.4.a).(2)	design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)	2.5.b.	The program director must design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program. (Core)
II.A.4.a).(3)	administer and maintain a learning environment conducive to educating the fellows in each of the ACGME Competency domains; (Core)	2.5.c.	environment conducive to educating the fellows in each of the ACGME Competency domains. (Core)
II.A.4.a).(4)	have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval; (Core)	2.5.d.	physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval. (Core)
II.A.4.a).(5)	have the authority to remove fellows from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)	2.5.e.	The program director must have the authority to remove fellows from supervising interactions and/or learning environments that do not meet the standards of the program. (Core)
II.A.4.a).(6)	submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)	2.5.f.	The program director must submit accurate and complete information required and requested by the DIO, GMEC, and ACGME. (Core)
II.A.4.a).(7)	opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)	2.5.g.	which fellows have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation. (Core)
II.A.4.a).(8)	ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, not to promote, or renew the appointment of a fellow; (Core)	2.5.h.	The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, not to promote, or renew the appointment of a fellow. (Core)
II.A.4.a).(9)	ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)	2.5.i.	The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination. (Core)
II.A.4.a).(9).(a)	Fellows must not be required to sign a non-competition guarantee or restrictive covenant. (Core)	3.1.	Fellows must not be required to sign a non-competition guarantee or restrictive covenant. (Core)
II.A.4.a).(10)	document verification of education for all fellows within 30 days of completion of or departure from the program; (Core)	2.5.j.	fellows within 30 days of completion of or departure from the program. (Core)
II.A.4.a).(11)	provide verification of an individual fellow's education upon the fellow's request, within 30 days; and, (Core)	2.5.k.	The program director must provide verification of an individual fellow's education upon the fellow's request, within 30 days. (Core)
II.A.4.a).(12)	provide applicants who are offered an interview with information related to their eligibility for the relevant specialty board examination(s). (Core)	2.5.l.	with information related to their eligibility for the relevant specialty board examination(s). (Core)

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II.B.	**Faculty** ***Faculty members are a foundational element of graduate medical education – faculty members teach fellows how to care for patients. Faculty members provide an important bridge allowing fellows to grow and become practice ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.*** ***Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, fellows, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the fellows and themselves.***	**[None]**	***Faculty*** ***Faculty members are a foundational element of graduate medical education – faculty members teach fellows how to care for patients. Faculty members provide an important bridge allowing fellows to grow and become practice ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.*** ***Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, fellows, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the fellows and themselves.***
II.B.	***themselves.***	**[None]**	***themselves.***
II.B.1.	**There must be a sufficient number of faculty members with competence to instruct and supervise all fellows. (Core)**	**2.6.**	**There must be a sufficient number of faculty members with competence to instruct and supervise all fellows. (Core)**
II.B.1.a)	At least one faculty member must have expertise administering a hospice and palliative medicine program. (Core)	2.6.a.	At least one faculty member must have expertise administering a hospice and palliative medicine program. (Core)
II.B.1.b)	Because of the nature of hospice and palliative medicine, the physician faculty should include representatives from appropriate medical subspecialties such as cardiology, critical care medicine, geriatric medicine, addiction medicine, and oncology, and from other specialties, such as anesthesiology, emergency medicine, family medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, physical medicine and rehabilitation, psychiatry, radiation oncology, and surgery. (Detail)	2.6.b.	Because of the nature of hospice and palliative medicine, the physician faculty should include representatives from appropriate medical subspecialties such as cardiology, critical care medicine, geriatric medicine, addiction medicine, and oncology, and from other specialties, such as anesthesiology, emergency medicine, family medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, physical medicine and rehabilitation, psychiatry, radiation oncology, and surgery. (Detail)
II.B.1.c)	Nurses, psychosocial clinicians (social workers or psychologists), and chaplains must have an active and defined role in teaching fellows. (Core)	2.6.c.	Nurses, psychosocial clinicians (social workers or psychologists), and chaplains must have an active and defined role in teaching fellows. (Core)
II.B.2	**Faculty members must:**	**[None]**	
II.B.2.a)	**be role models of professionalism; (Core)**	**2.7.**	**Faculty Responsibilities** **Faculty members must be role models of professionalism. (Core)**
II.B.2.b)	**demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care; (Core)**	**2.7.a.**	**Faculty members must demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care. (Core)**
II.B.2.c)	**demonstrate a strong interest in the education of fellows, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)**	**2.7.b.**	**Faculty members must demonstrate a strong interest in the education of fellows, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. (Core)**
II.B.2.d)	**administer and maintain an educational environment conducive to educating fellows; (Core)**	**2.7.c.**	**Faculty members must administer and maintain an educational environment conducive to educating fellows. (Core)**

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II.B.2.e)	**regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)**	**2.7.d.**	**Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Core)**
II.B.2.f)	**pursue faculty development designed to enhance their skills. (Core)**	**2.7.e.**	**Faculty members must pursue faculty development designed to enhance their skills. (Core)**
II.B.3.	**Faculty Qualifications**	**2.8.**	**Faculty Qualifications** **Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)**
II.B.3.a)	**Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)**	**2.8.**	**Faculty Qualifications** **Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)**
II.B.3.b)	**Subspecialty physician faculty members must:**	**[None]**	
II.B.3.b).(1)	**have current certification in the subspecialty by the American Board of** Anesthesiology, Emergency Medicine, Family Medicine, Internal Medicine, Obstetrics and Gynecology, Pediatrics, Physical Medicine and Rehabilitation, Psychiatry and Neurology, Radiology, or Surgery **or by a certifying board of the American Osteopathic Association, or possess qualifications judged acceptable to the Review Committee. (Core)**	**2.9.**	**Subspecialty Physician Faculty Members** **Subspecialty physician faculty members must have current certification in the subspecialty by the American Board of** Anesthesiology, Emergency Medicine, Family Medicine, Internal Medicine, Obstetrics and Gynecology, Pediatrics, Physical Medicine and Rehabilitation, Psychiatry and Neurology, Radiology, or Surgery **or by a certifying board of the American Osteopathic Association, or possess qualifications judged acceptable to the Review Committee. (Core)**
II.B.3.c)	**Any other specialty physician faculty members must have current certification in their specialty by the appropriate American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board, or possess qualifications judged acceptable to the Review Committee. (Core)**	**2.9.a.**	**Any other specialty physician faculty members must have current certification in their specialty by the appropriate American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board, or possess qualifications judged acceptable to the Review Committee. (Core)**
II.B.4.	**Core faculty members must have a significant role in the education and supervision of fellows and must devote a significant portion of their entire effort to fellow education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to fellows. (Core)**	**2.10.**	**Core Faculty** **Core faculty members must have a significant role in the education and supervision of fellows and must devote a significant portion of their entire effort to fellow education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to fellows. (Core)**
II.B.4.a)	**(Core)**	**2.10.a.**	**Faculty members must complete the annual ACGME Faculty Survey. (Core)**

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II.B.4.b)	In addition to the program director, programs must have a minimum number of core faculty members certified in hospice and palliative medicine by the American Board of Anesthesiology, Emergency Medicine, Family Medicine, Internal Medicine, Obstetrics and Gynecology, Pediatrics, Physical Medicine and Rehabilitation, Psychiatry and Neurology, Radiology, or Surgery or the American Osteopathic Board of Emergency Medicine, Family Physicians, Internal Medicine, Neurology and Psychiatry, or Physical Medicine and Rehabilitation, based on the number of approved fellow positions as follows:. (Core) Number of Approved Fellow Positions: 1-3 | Minimum Number of Certified Core Faculty Members: 1 Number of Approved Fellow Positions: 4-6 | Minimum Number of ABMS or AOA Subspecialty Certified Core Faculty Members: 3 Number of Approved Fellow Positions: 7-9 | Minimum Number of ABMS or AOA Subspecialty Certified Core Faculty Members: 4 Number of Approved Fellow Positions: 10-12 | Minimum Number of ABMS or AOA Subspecialty Certified Core Faculty Members: 6 Number of Approved Fellow Positions: 13-15 | Minimum Number of ABMS or AOA Subspecialty Certified Core Faculty Members: 8 Number of Approved Fellow Positions: 16-18 | Minimum Number of ABMS or AOA Subspecialty Certified Core Faculty Members: 10 Number of Approved Fellow Positions: >18 | Minimum Number of ABMS or AOA Subspecialty Certified Core Faculty Members: 12	2.10.b.	In addition to the program director, programs must have a minimum number of core faculty members certified in hospice and palliative medicine by the American Board of Anesthesiology, Emergency Medicine, Family Medicine, Internal Medicine, Obstetrics and Gynecology, Pediatrics, Physical Medicine and Rehabilitation, Psychiatry and Neurology, Radiology, or Surgery or the American Osteopathic Board of Emergency Medicine, Family Physicians, Internal Medicine, Neurology and Psychiatry, or Physical Medicine and Rehabilitation, based on the number of approved fellow positions as follows:. (Core) Number of Approved Fellow Positions: 1-3 | Minimum Number of Certified Core Faculty Members: 1 Number of Approved Fellow Positions: 4-6 | Minimum Number of ABMS or AOA Subspecialty Certified Core Faculty Members: 3 Number of Approved Fellow Positions: 7-9 | Minimum Number of ABMS or AOA Subspecialty Certified Core Faculty Members: 4 Number of Approved Fellow Positions: 10-12 | Minimum Number of ABMS or AOA Subspecialty Certified Core Faculty Members: 6 Number of Approved Fellow Positions: 13-15 | Minimum Number of ABMS or AOA Subspecialty Certified Core Faculty Members: 8 Number of Approved Fellow Positions: 16-18 | Minimum Number of ABMS or AOA Subspecialty Certified Core Faculty Members: 10 Number of Approved Fellow Positions: >18 | Minimum Number of ABMS or AOA Subspecialty Certified Core Faculty Members: 12
II.B.4.c)	The required core faculty members, in aggregate and excluding program leadership, must be provided with support equal to a minimum of 10 percent/FTE for educational and administrative responsibilities that do not involve direct patient care. Support must be provided based on the program size as follows: (Core) Number of Approved Positions: <7 | Minimum Aggregate Support Required (FTE): 0.10 Number of Approved Positions: 7-9 | Minimum Aggregate Support Required (FTE): 0.15 Number of Approved Positions: 10-12 | Minimum Aggregate Support Required (FTE): 0.15 Number of Approved Positions: 13-15 | Minimum Aggregate Support Required (FTE): 0.20 Number of Approved Positions: 16-18 | Minimum Aggregate Support Required (FTE): 0.20 Number of Approved Positions: >18 | Minimum Aggregate Support Required (FTE): 0.25	2.10.c.	The required core faculty members, in aggregate and excluding program leadership, must be provided with support equal to a minimum of 10 percent/FTE for educational and administrative responsibilities that do not involve direct patient care. Support must be provided based on the program size as follows: (Core) Number of Approved Positions: <7 | Minimum Aggregate Support Required (FTE): 0.10 Number of Approved Positions: 7-9 | Minimum Aggregate Support Required (FTE): 0.15 Number of Approved Positions: 10-12 | Minimum Aggregate Support Required (FTE): 0.15 Number of Approved Positions: 13-15 | Minimum Aggregate Support Required (FTE): 0.20 Number of Approved Positions: 16-18 | Minimum Aggregate Support Required (FTE): 0.20 Number of Approved Positions: >18 | Minimum Aggregate Support Required (FTE): 0.25
II.C.	**Program Coordinator**	**2.11.**	**Program Coordinator** **There must be administrative support for program coordination. (Core)**
II.C.1.	**There must be administrative support for program coordination. (Core)**	**2.11.**	**Program Coordinator** **There must be administrative support for program coordination. (Core)**

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II.C.1.a)	At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program. Additional administrative support must be provided based on the program size as follows: (Core) Number of Approved Fellow Positions: 1-3 | Minimum FTE Required for Coordinator Support: 0.30 | Additional Aggregate FTE Required for Administration of the Program: 0 Number of Approved Fellow Positions: 4-6 | Minimum FTE Required for Coordinator Support: 0.30 | Additional Aggregate FTE Required for Administration of the Program: 0.20 Number of Approved Fellow Positions: 7-9 | Minimum FTE Required for Coordinator Support: 0.30 | Additional Aggregate FTE Required for Administration of the Program: 0.38 Number of Approved Fellow Positions: 10-12 | Minimum FTE Required for Coordinator Support: 0.30 | Additional Aggregate FTE Required for Administration of the Program: 0.44	2.11.a.	At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program. Additional administrative support must be provided based on the program size as follows: (Core) Number of Approved Fellow Positions: 1-3 | Minimum FTE Required for Coordinator Support: 0.30 | Additional Aggregate FTE Required for Administration of the Program: 0 Number of Approved Fellow Positions: 4-6 | Minimum FTE Required for Coordinator Support: 0.30 | Additional Aggregate FTE Required for Administration of the Program: 0.20 Number of Approved Fellow Positions: 7-9 | Minimum FTE Required for Coordinator Support: 0.30 | Additional Aggregate FTE Required for Administration of the Program: 0.38 Number of Approved Fellow Positions: 10-12 | Minimum FTE Required for Coordinator Support: 0.30 | Additional Aggregate FTE Required for Administration of the Program: 0.44
II.C.1.a) - (Continued)	Number of Approved Fellow Positions: 13-15 | Minimum FTE Required for Coordinator Support: 0.30 | Additional Aggregate FTE Required for Administration of the Program: 0.50 Number of Approved Fellow Positions: 16-18 | Minimum FTE Required for Coordinator Support: 0.30 | Additional Aggregate FTE Required for Administration of the Program: 0.56 Number of Approved Fellow Positions: >18 | Minimum FTE Required for Coordinator Support: 0.30 | Additional Aggregate FTE Required for Administration of the Program: 0.62	2.11.a. - (Continued)	Number of Approved Fellow Positions: 13-15 | Minimum FTE Required for Coordinator Support: 0.30 | Additional Aggregate FTE Required for Administration of the Program: 0.50 Number of Approved Fellow Positions: 16-18 | Minimum FTE Required for Coordinator Support: 0.30 | Additional Aggregate FTE Required for Administration of the Program: 0.56 Number of Approved Fellow Positions: >18 | Minimum FTE Required for Coordinator Support: 0.30 | Additional Aggregate FTE Required for Administration of the Program: 0.62
II.D.	**Other Program Personnel** **The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)**	**2.12.**	**Other Program Personnel** **The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)**
III.	**Fellow Appointments**	**Section 3**	**Section 3: Fellow Appointments**
III.A.	**Eligibility Criteria**	**[None]**	

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	~~Eligibility Requirements – Fellowship Programs~~		**~~Eligibility Requirements – Fellowship Programs~~**
III.A.1.	**All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, an AOA-approved residency program, a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or a Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency program located in Canada. (Core)**	**3.2.**	**All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, an AOA-approved residency program, a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or a Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency program located in Canada. (Core)**
III.A.1.a)	**Fellowship programs must receive verification of each entering fellow's level of competence in the required field using ACGME, ACGME-I, or CanMEDS Milestones evaluations from the core residency program. (Core)**	**3.2.a.**	**Fellowship programs must receive verification of each entering fellow's level of competence in the required field using ACGME, ACGME-I, or CanMEDS Milestones evaluations from the core residency program. (Core)**
III.A.1.b)	Prior to appointment in the program, fellows must have prerequisite education in a residency program that satisfies III.A.1. as follows: completion of a residency program in child neurology, family medicine, internal medicine, pediatrics, physical medicine and rehabilitation, neurology, or radiation oncology; or, at least three clinical years in residency program that satisfies III.A.1. in anesthesiology, emergency medicine, obstetrics and gynecology, psychiatry, radiology, or surgery. (Core)	3.2.a.1.	Prior to appointment in the program, fellows must have prerequisite education in a residency program that satisfies 3.2. as follows: completion of a residency program in child neurology, family medicine, internal medicine, pediatrics, physical medicine and rehabilitation, neurology, or radiation oncology; or, at least three clinical years in residency program that satisfies 3.2. in anesthesiology, emergency medicine, obstetrics and gynecology, psychiatry, radiology, or surgery. (Core)
III.A.1.c)	**The Review Committees for** Family Medicine, Internal Medicine, Pediatrics, and Psychiatry **will allow the following exception to the fellowship eligibility requirements:**	**3.2.b.**	**The Review Committees for** Family Medicine, Internal Medicine, Pediatrics, and Psychiatry **will allow the following exception to the fellowship eligibility requirements:**
III.A.1.c).(1)	**qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1., but who does meet all of the following additional qualifications and conditions: (Core)**	**3.2.b.1.**	**qualified international graduate applicant who does not satisfy the eligibility requirements listed in 3.2., but who does meet all of the following additional qualifications and conditions: (Core)**
III.A.1.c).(1).(a)	**evaluation by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and, (Core)**	**3.2.b.1.a.**	**evaluation by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and, (Core)**
III.A.1.c).(1).(b)	**review and approval of the applicant's exceptional qualifications by the GMEC; and, (Core)**	**3.2.b.1.b.**	**review and approval of the applicant's exceptional qualifications by the GMEC; and, (Core)**
III.A.1.c).(1).(c)	**verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification. (Core)**	**3.2.b.1.c.**	**verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification. (Core)**
III.A.1.c).(2)	**their performance by the Clinical Competency Committee within 12 weeks of matriculation. (Core)**	**3.2.b.2.**	**their performance by the Clinical Competency Committee within 12 weeks of matriculation. (Core)**
III.B.	**Fellow Complement** **The program director must not appoint more fellows than approved by the Review Committee. (Core)**	**3.3.**	**Fellow Complement** **The program director must not appoint more fellows than approved by the Review Committee. (Core)**

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IV.	**Educational Program** **The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.** **The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.** **It is recognized that programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.**	Section 4	**Section 4: Educational Program** ***The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.*** ***The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.*** ***It is recognized that programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.***
IV.A.	**Educational Components** **The curriculum must contain the following educational components:**	4.2.	**Educational Components** **The curriculum must contain the following educational components:**
IV.A.1.	**a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, fellows, and faculty members; (Core)**	4.2.a.	**a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, fellows, and faculty members; (Core)**
IV.A.2.	**designed to promote progress on a trajectory to autonomous practice in their subspecialty. These must be distributed, reviewed, and available to fellows and faculty members; (Core)**	4.2.b.	**designed to promote progress on a trajectory to autonomous practice in their subspecialty. These must be distributed, reviewed, and available to fellows and faculty members; (Core)**
IV.A.3.	**responsibility for patient management, and graded supervision in their subspecialty; (Core)**	4.2.c.	**responsibility for patient management, and graded supervision in their subspecialty; (Core)**
IV.A.4.	**structured educational activities beyond direct patient care; and, (Core)**	4.2.d.	**structured educational activities beyond direct patient care; and, (Core)**
IV.A.4.a)	**Fellows must be provided with protected time to participate in core didactic activities. (Core)**	4.11.	**Curriculum Organization and Fellow Experiences – Didactic and Clinical Experiences** **Fellows must be provided with protected time to participate in core didactic activities. (Core)**
IV.A.5.	**formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)**	4.2.e.	**formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)**
IV.B.	**ACGME Competencies**	[None]	**ACGME Competencies** ***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.***
IV.B.1.	**curriculum:**	[None]	**The program must integrate all ACGME Competencies into the curriculum.**

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IV.B.1.a)	**Professionalism** **Fellows must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)**	**4.3.**	**ACGME Competencies – Professionalism** **Fellows must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)**
IV.B.1.b)	**Patient Care and Procedural Skills**	**[None]**	
IV.B.1.b).(1)	**Fellows must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)**	**4.4.**	**ACGME Competencies – Patient Care** **Fellows must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)**
IV.B.1.b).(1).(a)	Fellows must demonstrate competence coordinating, leading, and facilitating key events in patient care, such as family meetings, consultation around goals of care, advance directive completion, conflict resolution, withdrawal of life-sustaining therapies, and palliative sedation, involving other team members as appropriate. (Core)	4.4.a.	Fellows must demonstrate competence coordinating, leading, and facilitating key events in patient care, such as family meetings, consultation around goals of care, advance directive completion, conflict resolution, withdrawal of life-sustaining therapies, and palliative sedation, involving other team members as appropriate. (Core)
IV.B.1.b).(1).(b)	Fellows must demonstrate competence in providing care to patients and families that reflects unique characteristics of different settings along the palliative care spectrum. (Core)	4.4.b.	Fellows must demonstrate competence in providing care to patients and families that reflects unique characteristics of different settings along the palliative care spectrum. (Core)
IV.B.1.b).(1).(c)	Fellows must demonstrate competence in recognizing signs and symptoms of impending death and appropriately caring for the imminently dying patient and the patient's family members. (Core)	4.4.c.	Fellows must demonstrate competence in recognizing signs and symptoms of impending death and appropriately caring for the imminently dying patient and the patient's family members. (Core)
IV.B.1.b).(1).(d)	Fellows must demonstrate basic counseling to the bereaved, and the ability to identify when additional psychosocial referral is required. (Core)	4.4.d.	Fellows must demonstrate basic counseling to the bereaved, and the ability to identify when additional psychosocial referral is required. (Core)
IV.B.1.b).(1).(e)	Fellows must demonstrate competence in providing palliative care throughout the continuum of serious illness while addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice. (Core)	4.4.e.	Fellows must demonstrate competence in providing palliative care throughout the continuum of serious illness while addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice. (Core)
IV.B.1.b).(2)	**Fellows must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)**	**4.5.**	**ACGME Competencies – Procedural Skills** **Fellows must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)**
IV.B.1.b).(2).(a)	Fellows must demonstrate competence in the assessment, interdisciplinary care planning, management, coordination, and follow-up of patients with serious illness. (Core)	4.5.a.	Fellows must demonstrate competence in the assessment, interdisciplinary care planning, management, coordination, and follow-up of patients with serious illness. (Core)
IV.B.1.b).(2).(a).(i)	Fellows must provide patient- and family-centered care that optimizes quality of life, by anticipating, preventing, and treating suffering. (Core)	4.5.a.1.	Fellows must provide patient- and family-centered care that optimizes quality of life, by anticipating, preventing, and treating suffering. (Core)
IV.B.1.c)	**Medical Knowledge** **Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)**	**4.6.**	**ACGME Competencies – Medical Knowledge** **Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)**

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IV.B.1.c).(1)	Fellows must demonstrate knowledge of the scientific method of problem solving and evidence-based decision making, and develop a commitment to lifelong learning and an attitude of caring that is derived from humanistic and professional values. (Core)	4.6.a.	Fellows must demonstrate knowledge of the scientific method of problem solving and evidence-based decision making, and develop a commitment to lifelong learning and an attitude of caring that is derived from humanistic and professional values. (Core)
IV.B.1.c).(2)	Fellows must demonstrate knowledge of ethical issues, clinical utilization, and financial outcomes of palliative care. (Core)	4.6.b.	Fellows must demonstrate knowledge of ethical issues, clinical utilization, and financial outcomes of palliative care. (Core)
IV.B.1.c).(3)	Fellows must demonstrate knowledge and skills of primary and consultative practice. (Core)	4.6.c.	Fellows must demonstrate knowledge and skills of primary and consultative practice. (Core)
IV.B.1.c).(4)	Fellows must demonstrate knowledge of structural and cultural barriers to the access or utilization of palliative services by individuals or groups of people. (Core)	4.6.d.	Fellows must demonstrate knowledge of structural and cultural barriers to the access or utilization of palliative services by individuals or groups of people. (Core)
IV.B.1.d)	**Practice-based Learning and Improvement** **Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. (Core)**	**4.7.**	**ACGME Competencies – Practice-Based Learning and Improvement** **Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. (Core)**
IV.B.1.e)	**Interpersonal and Communication Skills** **Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core)**	**4.8.**	**ACGME Competencies – Interpersonal and Communication Skills** **Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core)**
IV.B.1.f)	**Systems-based Practice** **Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)**	**4.9.**	**ACGME Competencies – Systems-Based Practice** **Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)**

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IV.C.	**Curriculum Organization and Fellow Experiences**	**4.10. - 4.12.**	**4.10. Curriculum Organization and Fellow Experiences – Curriculum Structure** **The curriculum must be structured to optimize fellow educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)** **4.11. Curriculum Organization and Fellow Experiences – Didactic and Clinical Experiences** **Fellows must be provided with protected time to participate in core didactic activities. (Core)** **4.12. Curriculum Organization and Fellow Experiences – Pain Management** **The program must provide instruction and experience in pain management if applicable for the subspecialty, including recognition of the signs of substance use disorder. (Core)**
IV.C.1.	**The curriculum must be structured to optimize fellow educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)**	**4.10.**	**Curriculum Organization and Fellow Experiences – Curriculum Structure** **The curriculum must be structured to optimize fellow educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)**
IV.C.1.a)	Rotations must be of sufficient length to provide longitudinal relationships with faculty members, and meaningful assessment and feedback. (Core)	4.10.a.	Rotations must be of sufficient length to provide longitudinal relationships with faculty members, and meaningful assessment and feedback. (Core)
IV.C.1.b)	Rotations must be structured to allow fellows to function as part of an effective interprofessional team that works together toward the shared goals of patient safety and quality improvement. (Core)	4.10.b.	Rotations must be structured to allow fellows to function as part of an effective interprofessional team that works together toward the shared goals of patient safety and quality improvement. (Core)
IV.C.1.c)	Schedules must be structured to minimize conflicting inpatient and outpatient responsibilities. (Core)	4.10.c.	Schedules must be structured to minimize conflicting inpatient and outpatient responsibilities. (Core)
IV.C.2.	**The program must provide instruction and experience in pain management if applicable for the subspecialty, including recognition of the signs of substance use disorder. (Core)**	**4.12.**	**Curriculum Organization and Fellow Experiences – Pain Management** **The program must provide instruction and experience in pain management if applicable for the subspecialty, including recognition of the signs of substance use disorder. (Core)**
IV.C.3.	Fellows should have experience in at least one dedicated palliative care/hospice unit. (Detail)	4.11.a.	Fellows should have experience in at least one dedicated palliative care/hospice unit. (Detail)
IV.C.4.	Fellows must spend a minimum of four months or equivalent longitudinal experience in the inpatient setting, which may involve participation on a consultation team or on an inpatient unit, or both. (Core)	4.11.b.	Fellows must spend a minimum of four months or equivalent longitudinal experience in the inpatient setting, which may involve participation on a consultation team or on an inpatient unit, or both. (Core)

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IV.C.4.a)	The program must ensure that the inpatient setting provides access to a full range of services usually ascribed to an acute-care general hospital, including availability of diagnostic laboratory and imaging services. (Core)	4.11.b.1.	The program must ensure that the inpatient setting provides access to a full range of services usually ascribed to an acute-care general hospital, including availability of diagnostic laboratory and imaging services. (Core)
IV.C.4.b)	There must be access to a range of consulting physicians, including those with expertise in interventional pain management. (Core)	4.11.b.2.	There must be access to a range of consulting physicians, including those with expertise in interventional pain management. (Core)
IV.C.5.	Fellows should have a long-term care experience at a skilled nursing facility, chronic care hospital, or children's rehabilitation center. (Detail)	4.11.c.	Fellows should have a long-term care experience at a skilled nursing facility, chronic care hospital, or children's rehabilitation center. (Detail)
IV.C.5.a)	Fellows' long-term care experience should comprise a minimum of 25 patient visits or 100 hours and provide access to meaningful care of patients relevant to the identification and management of palliative issues in the long-term care population with serious illness, including awareness of the regulatory environment in which care is provided. (Detail)	4.11.c.1.	Fellows' long-term care experience should comprise a minimum of 25 patient visits or 100 hours and provide access to meaningful care of patients relevant to the identification and management of palliative issues in the long-term care population with serious illness, including awareness of the regulatory environment in which care is provided. (Detail)
IV.C.6.	The program must provide fellows a minimum of two months' experience with Medicare-certified hospice(s) or VA hospice care, or with a pediatric palliative care team caring for children with serious illness at home. (Core)	4.11.d.	The program must provide fellows a minimum of two months' experience with Medicare-certified hospice(s) or VA hospice care, or with a pediatric palliative care team caring for children with serious illness at home. (Core)
IV.C.6.a)	During this experience, the fellow must perform at least 25 hospice home visits through a Medicare-certified hospice. (Core)	4.11.d.1.	During this experience, the fellow must perform at least 25 hospice home visits through a Medicare-certified hospice. (Core)
IV.C.7.	Fellows must have supervised experience(s) in ambulatory setting(s) providing relevant palliative interventions to patients with serious conditions (Core)	4.11.e.	Fellows must have supervised experience(s) in ambulatory setting(s) providing relevant palliative interventions to patients with serious conditions (Core)
IV.C.7.(a)	Some of these experiences should be delivered via telehealth. (Detail)	4.11.e.1.	Some of these experiences should be delivered via telehealth. (Detail)
IV.C.7.(b)	The ambulatory experience(s) should include at least 32 half-days or 128 hours. (Detail)	4.11.e.2.	The ambulatory experience(s) should include at least 32 half-days or 128 hours. (Detail)
IV.C.7.(c)	Interdisciplinary care of patients must be available in each ambulatory setting. (Detail)	4.11.e.3.	Interdisciplinary care of patients must be available in each ambulatory setting. (Detail)
IV.C.8.	Fellow conferences or seminars/workshops in hospice and palliative medicine should be specifically designed to augment clinical experiences. (Detail)	4.11.f.	Fellow conferences or seminars/workshops in hospice and palliative medicine should be specifically designed to augment clinical experiences. (Detail)
IV.C.8.a)	Fellows must participate as both learners and teachers in supplemental educational offerings at conferences, communication skill workshops, lecture series, and similar activities. (Core)	4.11.f.1.	Fellows must participate as both learners and teachers in supplemental educational offerings at conferences, communication skill workshops, lecture series, and similar activities. (Core)
IV.C.8.b)	There must be a journal club or other activity that fosters interaction and develops skills in interpreting the medical literature. (Core)	4.11.f.2.	There must be a journal club or other activity that fosters interaction and develops skills in interpreting the medical literature. (Core)
IV.C.9.	Fellows must spend at least one month or equivalent of elective time in a clinically relevant field. Electives may include addiction medicine, cardiology, ethics consultations, geriatric medicine, HIV clinic, interventional pain management, medical oncology, medical psychiatry, neurology clinics, pediatrics, radiation oncology, pulmonology, or other experiences determined to be appropriate by the program director. (Core)	4.11.g.	Fellows must spend at least one month or equivalent of elective time in a clinically relevant field. Electives may include addiction medicine, cardiology, ethics consultations, geriatric medicine, HIV clinic, interventional pain management, medical oncology, medical psychiatry, neurology clinics, pediatrics, radiation oncology, pulmonology, or other experiences determined to be appropriate by the program director. (Core)
IV.C.10.	The program must ensure that fellows see at least 100 new patients over the course of the program. (Core)	4.11.h.	The program must ensure that fellows see at least 100 new patients over the course of the program. (Core)
IV.C.11.	Fellows should follow at least 10 patients longitudinally across settings. (Detail)	4.11.i.	Fellows should follow at least 10 patients longitudinally across settings. (Detail)

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IV.D.	**Scholarship** ***Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through fellow participation in scholarly activities as defined in the subspecialty-specific Program Requirements. Scholarly activities may include discovery, integration, application, and teaching.*** ***The ACGME recognizes the diversity of fellowships and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.***	**[None]**	**Scholarship** ***Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through fellow participation in scholarly activities as defined in the subspecialty-specific Program Requirements. Scholarly activities may include discovery, integration, application, and teaching.*** ***The ACGME recognizes the diversity of fellowships and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.***
IV.D.1.	**Program Responsibilities**	**4.13.**	**Program Responsibilities** **The program must demonstrate evidence of scholarly activities, consistent with its mission(s) and aims. (Core)**
IV.D.1.a)	**The program must demonstrate evidence of scholarly activities, consistent with its mission(s) and aims. (Core)**	**4.13.**	**Program Responsibilities** **The program must demonstrate evidence of scholarly activities, consistent with its mission(s) and aims. (Core)**
IV.D.2.	**Faculty Scholarly Activity**	**4.14.**	**Faculty Scholarly Activity** Hospice and palliative medicine faculty members must have a record of ongoing involvement in education and scholarly activities. (Core)
IV.D.2.a)	Hospice and palliative medicine faculty members must have a record of ongoing involvement in education and scholarly activities. (Core)	**4.14.**	**Faculty Scholarly Activity** Hospice and palliative medicine faculty members must have a record of ongoing involvement in education and scholarly activities. (Core)
IV.D.2.a).(1)	This should include mentoring fellows, serving as a clinical supervisor in an inpatient or outpatient setting, developing curricula, and/or participating in didactic activities. (Detail)	4.14.a.	This should include mentoring fellows, serving as a clinical supervisor in an inpatient or outpatient setting, developing curricula, and/or participating in didactic activities. (Detail)
IV.D.3.	**Fellow Scholarly Activity**	**4.15.**	**Fellow Scholarly Activity** Fellows must complete a scholarly or quality improvement project during the program. (Core)
IV.D.3.a)	Fellows must complete a scholarly or quality improvement project during the program. (Core)	**4.15.**	**Fellow Scholarly Activity** Fellows must complete a scholarly or quality improvement project during the program. (Core)
V.	**Evaluation**	**Section 5**	**Section 5: Evaluation**
V.A.	**Fellow Evaluation**	**5.1.**	**Fellow Evaluation: Feedback and Evaluation** **Faculty members must directly observe, evaluate, and frequently provide feedback on fellow performance during each rotation or similar educational assignment. (Core)**

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V.A.1.	Feedback and Evaluation	5.1.	Fellow Evaluation: Feedback and Evaluation Faculty members must directly observe, evaluate, and frequently provide feedback on fellow performance during each rotation or similar educational assignment. (Core)
V.A.1.a)	Faculty members must directly observe, evaluate, and frequently provide feedback on fellow performance during each rotation or similar educational assignment. (Core)	5.1.	Fellow Evaluation: Feedback and Evaluation Faculty members must directly observe, evaluate, and frequently provide feedback on fellow performance during each rotation or similar educational assignment. (Core)
V.A.1.b)	Evaluation must be documented at the completion of the assignment. (Core)	5.1.a.	Evaluation must be documented at the completion of the assignment. (Core)
V.A.1.b).(1)	Evaluations must be completed at least every three months. (Core)	5.1.a.1.	Evaluations must be completed at least every three months. (Core)
V.A.1.c)	The program must provide an objective performance evaluation based on the Competencies and the subspecialty-specific Milestones, and must: (Core)	5.1.b.	The program must provide an objective performance evaluation based on the Competencies and the subspecialty-specific Milestones, and must: (Core)
V.A.1.c).(1)	use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)	5.1.b.1.	use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)
V.A.1.c).(2)	provide that information to the Clinical Competency Committee for its synthesis of progressive fellow performance and improvement toward unsupervised practice. (Core)	5.1.b.2.	provide that information to the Clinical Competency Committee for its synthesis of progressive fellow performance and improvement toward unsupervised practice. (Core)
V.A.1.d)	The program director or their designee, with input from the Clinical Competency Committee, must:	[None]	
V.A.1.d).(1)	meet with and review with each fellow their documented semi-annual evaluation of performance, including progress along the subspecialty-specific Milestones; (Core)	5.1.c.	The program director or their designee, with input from the Clinical Competency Committee, must meet with and review with each fellow their documented semi-annual evaluation of performance, including progress along the subspecialty-specific Milestones. (Core)
V.A.1.d).(2)	develop plans for fellows failing to progress, following institutional policies and procedures. (Core)	5.1.d.	The program director or their designee, with input from the Clinical Competency Committee, must develop plans for fellows failing to progress, following institutional policies and procedures. (Core)
V.A.1.e)	The evaluations of a fellow’s performance must be accessible for review by the fellow. (Core)	5.1.e.	The evaluations of a fellow’s performance must be accessible for review by the fellow. (Core)
V.A.2.	Final Evaluation	5.2.	Fellow Evaluation: Final Evaluation The program director must provide a final evaluation for each fellow upon completion of the program. (Core)
V.A.2.a)	The program director must provide a final evaluation for each fellow upon completion of the program. (Core)	5.2.	Fellow Evaluation: Final Evaluation The program director must provide a final evaluation for each fellow upon completion of the program. (Core)
V.A.2.a).(1)	The subspecialty-specific Milestones, and when applicable the subspecialty-specific Case Logs, must be used as tools to ensure fellows are able to engage in autonomous practice upon completion of the program. (Core)	5.2.a.	The subspecialty-specific Milestones, and when applicable the subspecialty-specific Case Logs, must be used as tools to ensure fellows are able to engage in autonomous practice upon completion of the program. (Core)
V.A.2.a).(2)	The final evaluation must:	[None]	
V.A.2.a).(2).(a)	become part of the fellow’s permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy; (Core)	5.2.b.	The final evaluation must become part of the fellow’s permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy. (Core)

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V.A.2.a).(2).(b)	verify that the fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; and, (Core)	5.2.c.	The final evaluation must verify that the fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice. (Core)
V.A.2.a).(2).(c)	be shared with the fellow upon completion of the program. (Core)	5.2.d.	The final evaluation must be shared with the fellow upon completion of the program. (Core)
V.A.3.	A Clinical Competency Committee must be appointed by the program director. (Core)	5.3.	Clinical Competency Committee A Clinical Competency Committee must be appointed by the program director. (Core)
V.A.3.a)	At a minimum the Clinical Competency Committee must include three members, at least one of whom is a core faculty member. Members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows. (Core)	5.3.a.	At a minimum the Clinical Competency Committee must include three members, at least one of whom is a core faculty member. Members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows. (Core)
V.A.3.b)	The Clinical Competency Committee must:	[None]	
V.A.3.b).(1)	review all fellow evaluations at least semi-annually; (Core)	5.3.b.	The Clinical Competency Committee must review all fellow evaluations at least semi-annually. (Core)
V.A.3.b).(2)	determine each fellow's progress on achievement of the subspecialty-specific Milestones; and, (Core)	5.3.c.	The Clinical Competency Committee must determine each fellow's progress on achievement of the subspecialty-specific Milestones. (Core)
V.A.3.b).(3)	meet prior to the fellows' semi-annual evaluations and advise the program director regarding each fellow's progress. (Core)	5.3.d.	The Clinical Competency Committee must meet prior to the fellows' semi-annual evaluations and advise the program director regarding each fellow's progress. (Core)
V.B.	Faculty Evaluation	5.4.	Faculty Evaluation The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)
V.B.1.	The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)	5.4.	Faculty Evaluation The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)
V.B.1.a)	This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)	5.4.a.	This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)
V.B.1.b)	This evaluation must include written, confidential evaluations by the fellows. (Core)	5.4.b.	This evaluation must include written, confidential evaluations by the fellows. (Core)
V.B.2.	Faculty members must receive feedback on their evaluations at least annually. (Core)	5.4.c.	Faculty members must receive feedback on their evaluations at least annually. (Core)
V.C.	Program Evaluation and Improvement	5.5.	Program Evaluation and Improvement The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)
V.C.1	The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)	5.5.	Program Evaluation and Improvement The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)

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V.C.1.a)	The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one fellow. (Core)	5.5.a.	The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one fellow. (Core)
V.C.1.b)	Program Evaluation Committee responsibilities must include:	[None]	
V.C.1.b).(1)	review of the program's self-determined goals and progress toward meeting them; (Core)	5.5.b.	Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them. (Core)
V.C.1.b).(2)	guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)	5.5.c.	Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes. (Core)
V.C.1.b).(3)	review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)	5.5.d.	Program Evaluation Committee responsibilities must include review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)
V.C.1.c)	The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate fellow and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)	5.5.e.	The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate fellow and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)
V.C.1.d)	The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)	5.5.f.	The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)
V.C.1.e)	The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the members of the teaching faculty and the fellows, and be submitted to the DIO. (Core)	5.5.g.	The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the members of the teaching faculty and the fellows, and be submitted to the DIO. (Core)
V.C.2.	The program must participate in a Self-Study and submit it to the DIO. (Core)	5.5.h.	The program must participate in a Self-Study and submit it to the DIO. (Core)
V.C.3.	*One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.* *The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.*	[None]	Board Certification *One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.* *The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.*
V.C.3.a)	For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)	5.6.	Board Certification For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)
V.C.3.b)	For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)	5.6.a.	For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)

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V.C.3.c)	For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)	5.6.b.	For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)
V.C.3.d)	For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)	5.6.c.	For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)
V.C.3.e)	For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that subspecialty. (Outcome)	5.6.d.	For each of the exams referenced in 5.6. – 5.6.c., any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that subspecialty. (Outcome)
V.C.3.f)	Programs must report, in ADS, board certification status annually for the cohort of board-eligible fellows that graduated seven years earlier. (Core)	5.6.e.	Programs must report, in ADS, board certification status annually for the cohort of board-eligible fellows that graduated seven years earlier. (Core)
VI.	The Learning and Working Environment *Fellowship education must occur in the context of a learning and working environment that emphasizes the following principles:* *•Excellence in the safety and quality of care rendered to patients by fellows today* *•Excellence in the safety and quality of care rendered to patients by today's fellows in their future practice* *•Excellence in professionalism* *•Appreciation for the privilege of providing care for patients* *•Commitment to the well-being of the students, residents, fellows, faculty members, and all members of the health care team*	Section 6	Section 6: The Learning and Working Environment *Fellowship education must occur in the context of a learning and working environment that emphasizes the following principles:* *•Excellence in the safety and quality of care rendered to patients by fellows today* *•Excellence in the safety and quality of care rendered to patients by today's fellows in their future practice* *•Excellence in professionalism* *•Appreciation for the privilege of providing care for patients* *•Commitment to the well-being of the students, residents, fellows, faculty members, and all members of the health care team*
VI.A.	Patient Safety, Quality Improvement, Supervision, and Accountability	[None]	
VI.A.1.	Patient Safety and Quality Improvement	[None]	
VI.A.1.a)	Patient Safety	[None]	
VI.A.1.a).(1)	Culture of Safety *A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.*	[None]	Culture of Safety *A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.*

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VI.A.1.a).(1).(a)	The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)	6.1.	The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)
VI.A.1.a).(2)	Patient Safety Events *Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.*	[None]	Patient Safety Events *Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.*
VI.A.1.a).(2).(a)	Residents, fellows, faculty members, and other clinical staff members must:	[None]	
VI.A.1.a).(2).(a).(i)	know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events; (Core)	6.2.	Residents, fellows, faculty members, and other clinical staff members must know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events. (Core)
VI.A.1.a).(2).(a).(ii)	be provided with summary information of their institution's patient safety reports. (Core)	6.2.a.	Residents, fellows, faculty members, and other clinical staff members must be provided with summary information of their institution's patient safety reports. (Core)
VI.A.1.a).(2).(b)	Fellows must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)	6.3.	Fellows must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)
VI.A.1.a).(3)	Quality Metrics *Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.*	[None]	Quality Metrics *Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.*
VI.A.1.a).(3).(a)	Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)	6.4.	Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)
VI.A.2.	Supervision and Accountability	[None]	Supervision and Accountability *Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.* *Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.*

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VI.A.2.a)	***Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.*** ***Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.***	[None]	**Supervision and Accountability** ***Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.*** ***Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.***
VI.A.2.a).(1)	**Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)**	**6.5.**	**Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.**
VI.A.2.a).(1).(a)	**This information must be available to fellows, faculty members, other members of the health care team, and patients. (Core)**	**6.5.a.**	**This information must be available to fellows, faculty members, other members of the health care team, and patients. (Core)**
VI.A.2.a).(2)	**The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)**	**6.6.**	**The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)**
VI.A.2.b)	**Levels of Supervision** **To promote appropriate fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:**	**[None]**	**Levels of Supervision** ***To promote appropriate fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision.***
VI.A.2.b).(1)	**Direct Supervision:**	**6.7.**	**Direct Supervision** ***The supervising physician is physically present with the fellow during the key portions of the patient interaction.*** ***The supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.***
VI.A.2.b).(1).(a)	**the supervising physician is physically present with the fellow during the key portions of the patient interaction; or,**	**6.7.**	**Direct Supervision** ***The supervising physician is physically present with the fellow during the key portions of the patient interaction.*** ***The supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.***

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VI.A.2.b).(1).(b)	the supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.	6.7.	Direct Supervision *The supervising physician is physically present with the fellow during the key portions of the patient interaction.* *The supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.*
VI.A.2.b).(2)	Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the fellow for guidance and is available to provide appropriate direct supervision.	[None]	Indirect Supervision *The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the fellow for guidance and is available to provide appropriate direct supervision.*
VI.A.2.b).(3)	Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.	[None]	Oversight *The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.*
VI.A.2.c)	The program must define when physical presence of a supervising physician is required. (Core)	6.8.	The program must define when physical presence of a supervising physician is required. (Core)
VI.A.2.d)	The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. (Core)	6.9.	The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. (Core)
VI.A.2.d).(1)	The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones. (Core)	6.9.a.	The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones. (Core)
VI.A.2.d).(2)	Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow. (Core)	6.9.b.	Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow. (Core)
VI.A.2.d).(3)	Fellows should serve in a supervisory role to junior fellows and residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)	6.9.c.	Fellows should serve in a supervisory role to junior fellows and residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)
VI.A.2.e)	Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s). (Core)	6.10.	Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s). (Core)
VI.A.2.e).(1)	Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence. (Outcome)	6.10.a.	Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence. (Outcome)
VI.A.2.f)	Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each fellow and to delegate to the fellow the appropriate level of patient care authority and responsibility. (Core)	6.11.	Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each fellow and to delegate to the fellow the appropriate level of patient care authority and responsibility. (Core)
VI.B.	Professionalism	6.12.	Professionalism Programs, in partnership with their Sponsoring Institutions, must educate fellows and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

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VI.B.1.	Programs, in partnership with their Sponsoring Institutions, must educate fellows and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)	6.12.	Professionalism Programs, in partnership with their Sponsoring Institutions, must educate fellows and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)
VI.B.2.	The learning objectives of the program must:	[None]	
VI.B.2.a)	be accomplished without excessive reliance on fellows to fulfill non-physician obligations; (Core)	6.12.a.	The learning objectives of the program must be accomplished without excessive reliance on fellows to fulfill non-physician obligations. (Core)
VI.B.2.b)	ensure manageable patient care responsibilities; and, (Core)	6.12.b.	The learning objectives of the program must ensure manageable patient care responsibilities. (Core)
VI.B.2.c)	include efforts to enhance the meaning that each fellow finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships. (Core)	6.12.c.	The learning objectives of the program must include efforts to enhance the meaning that each fellow finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships. (Core)
VI.B.3.	The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)	6.12.d.	The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)
VI.B.4.	Fellows and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)	6.12.e.	Fellows and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)
VI.B.5.	Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, fellows, faculty, and staff. (Core)	6.12.f.	Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, fellows, faculty, and staff. (Core)
VI.B.6.	Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)	6.12.g.	Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

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VI.C.	**Well-Being** ***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. 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.***	[None]	**Well-Being** ***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. 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.***
VI.C.1.	**The responsibility of the program, in partnership with the Sponsoring Institution, must include:**	6.13.	**The responsibility of the program, in partnership with the Sponsoring Institution, must include:**
VI.C.1.a)	**attention to scheduling, work intensity, and work compression that impacts fellow well-being; (Core)**	6.13.a.	**attention to scheduling, work intensity, and work compression that impacts fellow well-being; (Core)**
VI.C.1.b)	**evaluating workplace safety data and addressing the safety of fellows and faculty members; (Core)**	6.13.b.	**evaluating workplace safety data and addressing the safety of fellows and faculty members; (Core)**
VI.C.1.c)	**policies and programs that encourage optimal fellow and faculty member well-being; and, (Core)**	6.13.c.	**policies and programs that encourage optimal fellow and faculty member well-being; and, (Core)**
VI.C.1.c).(1)	**Fellows must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)**	6.13.c.1.	**Fellows must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)**
VI.C.1.d)	**education of fellows and faculty members in:**	6.13.d.	**education of fellows and faculty members in:**
VI.C.1.d).(1)	**identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)**	6.13.d.1.	**identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)**
VI.C.1.d).(2)	**recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)**	6.13.d.2.	**recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)**
VI.C.1.d).(3)	**access to appropriate tools for self-screening. (Core)**	6.13.d.3.	**access to appropriate tools for self-screening. (Core)**
VI.C.1.e)	**providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)**	6.13.e.	**providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)**
VI.C.2.	**There are circumstances in which fellows may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for fellows unable to perform their patient care responsibilities. (Core)**	6.14.	**There are circumstances in which fellows may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for fellows unable to perform their patient care responsibilities. (Core)**

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VI.C.2.a)	**The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)**	**6.14.a.**	**The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)**
VI.C.2.b)	**These policies must be implemented without fear of negative consequences for the fellow who is or was unable to provide the clinical work. (Core)**	**6.14.b.**	**These policies must be implemented without fear of negative consequences for the fellow who is or was unable to provide the clinical work. (Core)**
VI.D.	**Fatigue Mitigation**	**6.15.**	**Fatigue Mitigation** **Programs must educate all fellows and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)**
VI.D.1.	**Programs must educate all fellows and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)**	**6.15.**	**Fatigue Mitigation** **Programs must educate all fellows and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)**
VI.D.2.	**The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for fellows who may be too fatigued to safely return home. (Core)**	**6.16.**	**The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for fellows who may be too fatigued to safely return home. (Core)**
VI.E.	**Clinical Responsibilities, Teamwork, and Transitions of Care**	**[None]**	
VI.E.1.	**Clinical Responsibilities** **The clinical responsibilities for each fellow must be based on PGY level, patient safety, fellow ability, severity and complexity of patient illness/condition, and available support services. (Core)**	**6.17.**	**Clinical Responsibilities** **The clinical responsibilities for each fellow must be based on PGY level, patient safety, fellow ability, severity and complexity of patient illness/condition, and available support services. (Core)**
VI.E.1.a)	The program director must have the authority and responsibility to set appropriate clinical responsibilities (i.e., patient caps) for each fellow. (Core)	6.17.a.	The program director must have the authority and responsibility to set appropriate clinical responsibilities (i.e., patient caps) for each fellow. (Core)
VI.E.2.	**Teamwork** **Fellows must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the subspecialty and larger health system. (Core)**	**6.18.**	**Teamwork** **Fellows must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the subspecialty and larger health system. (Core)**
VI.E.2.a)	Fellows must interact regularly with one or more interdisciplinary teams in the conduct of clinical care. This includes participating in regular team conferences with the interdisciplinary teams in order to coordinate the implementation of recommendations from these teams. (Core)	6.18.a.	Fellows must interact regularly with one or more interdisciplinary teams in the conduct of clinical care. This includes participating in regular team conferences with the interdisciplinary teams in order to coordinate the implementation of recommendations from these teams. (Core)
VI.E.2.a).(1)	The interdisciplinary teams must include physicians, nurses, psychosocial clinicians (such as a social workers or psychologists), and chaplains. (Core)	6.18.a.1.	The interdisciplinary teams must include physicians, nurses, psychosocial clinicians (such as a social workers or psychologists), and chaplains. (Core)
VI.E.3.	**Transitions of Care**	**6.19.**	**Transitions of Care** **Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)**
VI.E.3.a)	**Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)**	**6.19.**	**Transitions of Care** **Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)**
VI.E.3.b)	**Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)**	**6.19.a.**	**Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)**
VI.E.3.c)	**Programs must ensure that fellows are competent in communicating with team members in the hand-off process. (Outcome)**	**6.19.b.**	**Programs must ensure that fellows are competent in communicating with team members in the hand-off process. (Outcome)**

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VI.F.	Clinical Experience and Education Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide fellows with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.	[None]	Clinical Experience and Education *Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide fellows with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.*
VI.F.1.	Maximum Hours of Clinical and Educational Work per Week Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)	6.20.	Maximum Hours of Clinical and Educational Work per Week Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)
VI.F.2.	Mandatory Time Free of Clinical Work and Education	6.21.	Mandatory Time Free of Clinical Work and Education Fellows should have eight hours off between scheduled clinical work and education periods. (Detail)
VI.F.2.a)	Fellows should have eight hours off between scheduled clinical work and education periods. (Detail)	6.21.	Mandatory Time Free of Clinical Work and Education Fellows should have eight hours off between scheduled clinical work and education periods. (Detail)
VI.F.2.b)	Fellows must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)	6.21.a.	Fellows must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)
VI.F.2.c)	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)	6.21.b.	Fellows must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)
VI.F.3.	Maximum Clinical Work and Education Period Length	6.22.	Maximum Clinical Work and Education Period Length Clinical and educational work periods for fellows must not exceed 24 hours of continuous scheduled clinical assignments. (Core)
VI.F.3.a)	Clinical and educational work periods for fellows must not exceed 24 hours of continuous scheduled clinical assignments. (Core)	6.22.	Maximum Clinical Work and Education Period Length 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. Additional patient care responsibilities must not be assigned to a fellow during this time. (Core)	6.22.a.	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. Additional patient care responsibilities must not be assigned to a fellow during this time. (Core)
VI.F.4.	Clinical and Educational Work Hour Exceptions	6.23.	Clinical and Educational Work Hour Exceptions 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: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)

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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: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)**	6.23.	**Clinical and Educational Work Hour Exceptions** **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: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)**
VI.F.4.b)	**These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)**	6.23.a.	**These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)**
VI.F.4.c)	**A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.** The Review Committees will not consider requests for exceptions to the 80-hour limit to the fellows' work week.	6.24.	**A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.** The Review Committees will not consider requests for exceptions to the 80-hour limit to the fellows' work week.
VI.F.5.	**Moonlighting**	6.25.	**Moonlighting** **Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program, and must not interfere with the fellow's fitness for work nor compromise patient safety. (Core)**
VI.F.5.a)	**Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program, and must not interfere with the fellow's fitness for work nor compromise patient safety. (Core)**	6.25.	**Moonlighting** **Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program, and must not interfere with the fellow's fitness for work nor compromise patient safety. (Core)**
VI.F.5.b)	**Time spent by fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)**	6.25.a.	**Time spent by fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)**
VI.F.6.	**In-House Night Float** **Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core)**	6.26.	**In-House Night Float** **Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core)**
VI.F.7.	**Maximum In-House On-Call Frequency** **Fellows must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)**	6.27.	**Maximum In-House On-Call Frequency** **Fellows must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)**
VI.F.8.	**At-Home Call**	6.28.	**At-Home Call** **Time spent on patient care activities by fellows on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)**
VI.F.8.a)	**Time spent on patient care activities by fellows on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)**	6.28.	**At-Home Call** **Time spent on patient care activities by fellows on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
VI.F.8.a).(1)	At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow. (Core)	6.28.a.	At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow. (Core)