



**Accreditation Council for
Graduate Medical Education**

ACGME Common Program Requirements (Fellowship)

ACGME-approved focused revision: June 13, 2021; effective July 1, 2022
Editorial Revision: Background and Intent below II.C.2., VI.C., and VI.C.1.e) updated February 2022

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1 Common Program Requirements (Fellowship)
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3 Where applicable, text in italics describes the underlying philosophy of the requirements
4 in that section. These philosophic statements are not program requirements and are
5 therefore not citable.
6

7 Note: Review Committees may further specify only where indicated by “The Review
8 Committee may/must further specify.”
9

Background and Intent: These fellowship requirements reflect the fact that these learners have already completed the first phase of graduate medical education. Thus, this document is intended to explain the differences.

10 Introduction
11

12
13 **Int.A.** *Fellowship is advanced graduate medical education beyond a core
14 residency program for physicians who desire to enter more specialized
15 practice. Fellowship-trained physicians serve the public by providing
16 subspecialty care, which may also include core medical care, acting as a
17 community resource for expertise in their field, creating and integrating
18 new knowledge into practice, and educating future generations of
19 physicians. Graduate medical education values the strength that a diverse
20 group of physicians brings to medical care.*
21

22 *Fellows who have completed residency are able to practice independently
23 in their core specialty. The prior medical experience and expertise of
24 fellows distinguish them from physicians entering into residency training.
25 The fellow’s care of patients within the subspecialty is undertaken with
26 appropriate faculty supervision and conditional independence. Faculty
27 members serve as role models of excellence, compassion,
28 professionalism, and scholarship. The fellow develops deep medical
29 knowledge, patient care skills, and expertise applicable to their focused
30 area of practice. Fellowship is an intensive program of subspecialty clinical
31 and didactic education that focuses on the multidisciplinary care of
32 patients. Fellowship education is often physically, emotionally, and
33 intellectually demanding, and occurs in a variety of clinical learning
34 environments committed to graduate medical education and the well-being
35 of patients, residents, fellows, faculty members, students, and all members
36 of the health care team.*
37

38 *In addition to clinical education, many fellowship programs advance
39 fellows’ skills as physician-scientists. While the ability to create new
40 knowledge within medicine is not exclusive to fellowship-educated
41 physicians, the fellowship experience expands a physician’s abilities to
42 pursue hypothesis-driven scientific inquiry that results in contributions to
43 the medical literature and patient care. Beyond the clinical subspecialty
44 expertise achieved, fellows develop mentored relationships built on an
45 infrastructure that promotes collaborative research.*
46

47 **Int.B.** Definition of Subspecialty
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49 [The Review Committee must further specify]

50

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

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53 [The Review Committee must further specify]

54

55 **I. Oversight**

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57 **I.A. Sponsoring Institution**

58

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

62

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

66

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

67

68 **I.A.1. The program must be sponsored by one ACGME-accredited**
69 **Sponsoring Institution. ^{(Core)*}**

70

71 **I.B. Participating Sites**

72

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

75

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

78

79 [The Review Committee may specify which other
80 specialties/programs must be present at the primary clinical site
81 and/or the expected relationship with a core program in the
82 discipline]

83

84 **I.B.2. There must be a program letter of agreement (PLA) between the**
85 **program and each participating site that governs the relationship**
86 **between the program and the participating site providing a required**
87 **assignment. ^(Core)**

88

89 **I.B.2.a) The PLA must:**

90

91 I.B.2.a).(1) be renewed at least every 10 years; and, ^(Core)
92
93 I.B.2.a).(2) be approved by the designated institutional official
94 (DIO). ^(Core)
95

96 I.B.3. The program must monitor the clinical learning and working
97 environment at all participating sites. ^(Core)
98

99 I.B.3.a) At each participating site there must be one faculty member,
100 designated by the program director, who is accountable for
101 fellow education for that site, in collaboration with the
102 program director. ^(Core)
103

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

Suggested elements to be considered in PLAs will be found in the ACGME Program Director's Guide to the Common Program Requirements. These include:

- Identifying the faculty members who will assume educational and supervisory responsibility for fellows
- Specifying the responsibilities for teaching, supervision, and formal evaluation of fellows
- Specifying the duration and content of the educational experience
- Stating the policies and procedures that will govern fellow education during the assignment

104
105 I.B.4. The program director must submit any additions or deletions of
106 participating sites routinely providing an educational experience,
107 required for all fellows, of one month full time equivalent (FTE) or
108 more through the ACGME's Accreditation Data System (ADS). ^(Core)
109

[The Review Committee may further specify]

110
111
112 I.C. The program, in partnership with its Sponsoring Institution, must engage in
113 practices that focus on mission-driven, ongoing, systematic recruitment
114 and retention of a diverse and inclusive workforce of residents (if present),
115 fellows, faculty members, senior administrative staff members, and other
116 relevant members of its academic community. ^(Core)
117

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the

Sponsoring Institution's mission and aims. The program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce, as noted in V.C.1.c).(5).(c).

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I.D. Resources

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

[The Review Committee must further specify]

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

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

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

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

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

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

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

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

149 I.D.3. Fellows must have ready access to subspecialty-specific and other
150 appropriate reference material in print or electronic format. This
151 must include access to electronic medical literature databases with
152 full text capabilities. ^(Core)
153

154 I.D.4. The program's educational and clinical resources must be adequate
155 to support the number of fellows appointed to the program. ^(Core)
156

157 [The Review Committee may further specify]
158

159 I.E. *A fellowship program usually occurs in the context of many learners and
160 other care providers and limited clinical resources. It should be structured
161 to optimize education for all learners present.*
162

163 I.E.1. Fellows should contribute to the education of residents in core
164 programs, if present. ^(Core)
165

166 [The Review Committee may further specify]
167

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

168
169 II. Personnel

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171 II.A. Program Director

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173 II.A.1. There must be one faculty member appointed as program director
174 with authority and accountability for the overall program, including
175 compliance with all applicable program requirements. ^(Core)
176

177 II.A.1.a) The Sponsoring Institution's Graduate Medical Education
178 Committee (GMEC) must approve a change in program
179 director. ^(Core)
180

181 II.A.1.b) Final approval of the program director resides with the
182 Review Committee. ^(Core)
183

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

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185 II.A.2. The program director and, as applicable, the program’s leadership
186 team, must be provided with support adequate for administration of
187 the program based upon its size and configuration. ^(Core)

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189 [The Review Committee must further specify minimum dedicated
190 time for program administration, and will determine whether
191 program leadership refers to the program director or both the
192 program director and associate/assistant program director(s)]

193
194 [~~The Review Committee may further specify regarding support for~~
195 ~~associate program director(s)]~~

~~Background and Intent: Twenty percent FTE is defined as one day per week. [This number will be modified to fit the level of support specified by the Review Committee]~~

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

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

~~To achieve successful graduate medical education, individuals serving as education and administrative leaders of fellowship programs, as well as those significantly engaged in the education, supervision, evaluation, and mentoring of fellows, must have sufficient dedicated professional time to perform the vital activities required to sustain an accredited program.~~

~~The ultimate outcome of graduate medical education is excellence in fellow education and patient care.~~

~~The program director and, as applicable, the program leadership team, devote a portion of their professional effort to the oversight and management of the fellowship program, as defined in II.A.4.-II.A.4.a).(16). Both provision of support for the time required for the leadership effort and flexibility regarding how this support is provided are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.~~

~~Program directors and, as applicable, members of the program leadership team, who are new to the role may need to devote additional time to program oversight and management initially as they learn and become proficient in administering the program. It is suggested that during this initial period the support described above be increased as needed.~~

197
198 II.A.3. Qualifications of the program director:

199
200 II.A.3.a) must include subspecialty expertise and qualifications
201 acceptable to the Review Committee; and, ^(Core)

202
203 [The Review Committee may further specify]

204
205 **II.A.3.b)** must include current certification in the subspecialty for
206 which they are the program director by the American Board
207 of _____ or by the American Osteopathic Board of _____, or
208 subspecialty qualifications that are acceptable to the Review
209 Committee. ^(Core)

210
211 [The Review Committee may further specify acceptable
212 subspecialty qualifications or that only ABMS and AOA
213 certification will be considered acceptable]

214
215 [The Review Committee may further specify additional program
216 director qualifications]

217
218 **II.A.4. Program Director Responsibilities**

219
220 The program director must have responsibility, authority, and
221 accountability for: administration and operations; teaching and
222 scholarly activity; fellow recruitment and selection, evaluation, and
223 promotion of fellows, and disciplinary action; supervision of fellows;
224 and fellow education in the context of patient care. ^(Core)

225
226 **II.A.4.a) The program director must:**

227
228 **II.A.4.a).(1) be a role model of professionalism;** ^(Core)
229

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

230
231 **II.A.4.a).(2) design and conduct the program in a fashion**
232 **consistent with the needs of the community, the**
233 **mission(s) of the Sponsoring Institution, and the**
234 **mission(s) of the program;** ^(Core)
235

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

236
237 **II.A.4.a).(3) administer and maintain a learning environment**
238 **conducive to educating the fellows in each of the**
239 **ACGME Competency domains;** ^(Core)
240

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

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- II.A.4.a).(4)** develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the fellowship program education and at least annually thereafter, as outlined in V.B.; ^(Core)
- II.A.4.a).(5)** have the authority to approve program faculty members for participation in the fellowship program education at all sites; ^(Core)
- II.A.4.a).(6)** have the authority to remove program faculty members from participation in the fellowship program education at all sites; ^(Core)
- II.A.4.a).(7)** have the authority to remove fellows from supervising interactions and/or learning environments that do not meet the standards of the program; ^(Core)

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

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

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- II.A.4.a).(8)** submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; ^(Core)
- II.A.4.a).(9)** provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant subspecialty board examination(s); ^(Core)
- II.A.4.a).(10)** provide a learning and working environment in which fellows have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; ^(Core)
- II.A.4.a).(11)** ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; ^(Core)

277 II.A.4.a).(12) ensure the program’s compliance with the Sponsoring
278 Institution’s policies and procedures for due process
279 when action is taken to suspend or dismiss, not to
280 promote, or not to renew the appointment of a fellow;
281 (Core)
282

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

283
284 II.A.4.a).(13) ensure the program’s compliance with the Sponsoring
285 Institution’s policies and procedures on employment
286 and non-discrimination; (Core)
287

288 II.A.4.a).(13).(a) Fellows must not be required to sign a non-
289 competition guarantee or restrictive covenant.
290 (Core)
291

292 II.A.4.a).(14) document verification of program completion for all
293 graduating fellows within 30 days; (Core)
294

295 II.A.4.a).(15) provide verification of an individual fellow’s
296 completion upon the fellow’s request, within 30 days;
297 and, (Core)
298

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

299
300 II.A.4.a).(16) obtain review and approval of the Sponsoring
301 Institution’s DIO before submitting information or
302 requests to the ACGME, as required in the Institutional
303 Requirements and outlined in the ACGME Program
304 Director’s Guide to the Common Program
305 Requirements. (Core)
306

307 II.B. Faculty

308 *Faculty members are a foundational element of graduate medical education*
309 *– faculty members teach fellows how to care for patients. Faculty members*
310 *provide an important bridge allowing fellows to grow and become practice*
311 *ready, ensuring that patients receive the highest quality of care. They are*
312 *role models for future generations of physicians by demonstrating*
313 *compassion, commitment to excellence in teaching and patient care,*
314 *professionalism, and a dedication to lifelong learning. Faculty members*
315 *experience the pride and joy of fostering the growth and development of*
316 *future colleagues. The care they provide is enhanced by the opportunity to*
317

318 *teach. By employing a scholarly approach to patient care, faculty members,*
319 *through the graduate medical education system, improve the health of the*
320 *individual and the population.*

321
322 *Faculty members ensure that patients receive the level of care expected*
323 *from a specialist in the field. They recognize and respond to the needs of*
324 *the patients, fellows, community, and institution. Faculty members provide*
325 *appropriate levels of supervision to promote patient safety. Faculty*
326 *members create an effective learning environment by acting in a*
327 *professional manner and attending to the well-being of the fellows and*
328 *themselves.*
329

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

330
331 **II.B.1.** For each participating site, there must be a sufficient number of
332 **faculty members with competence to instruct and supervise all**
333 **fellows at that location.** ^(Core)

334
335 [The Review Committee may further specify]

336
337 **II.B.2.** Faculty members must:

338
339 **II.B.2.a)** be role models of professionalism; ^(Core)

340
341 **II.B.2.b)** demonstrate commitment to the delivery of safe, quality,
342 **cost-effective, patient-centered care;** ^(Core)
343

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

344
345 **II.B.2.c)** demonstrate a strong interest in the education of fellows; ^(Core)

346
347 **II.B.2.d)** devote sufficient time to the educational program to fulfill
348 **their supervisory and teaching responsibilities;** ^(Core)

349
350 **II.B.2.e)** administer and maintain an educational environment
351 **conducive to educating fellows;** ^(Core)

352
353 **II.B.2.f)** regularly participate in organized clinical discussions,
354 **rounds, journal clubs, and conferences; and,** ^(Core)

355
356 **II.B.2.g)** pursue faculty development designed to enhance their skills
357 **at least annually.** ^(Core)

358
359 [The Review Committee may further specify]

360

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

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II.B.3. Faculty Qualifications

II.B.3.a) Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments.
(Core)

[The Review Committee may further specify]

II.B.3.b) Subspecialty physician faculty members must:

II.B.3.b).(1) have current certification in the subspecialty by the American Board of _____ or the American Osteopathic Board of _____, or possess qualifications judged acceptable to the Review Committee. (Core)

[The Review Committee may further specify additional qualifications]

II.B.3.c) Any non-physician faculty members who participate in fellowship program education must be approved by the program director. (Core)

[The Review Committee may further specify]

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

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II.B.3.d) 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)

[The Review Committee may further specify]

II.B.4. Core Faculty

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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)

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

Core faculty members are critical to the success of fellow education. They support the program leadership in developing, implementing, and assessing curriculum, mentoring fellows, and assessing fellows' progress toward achievement of competence in and the independent practice of the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program. Core faculty members may also be selected for their specific expertise and unique contribution to the program. Core faculty members are engaged in a broad range of activities, which may vary across programs and specialties. Core faculty members provide clinical teaching and supervision of fellows, and also participate in non-clinical activities related to fellow education and program administration. Examples of these non-clinical activities include, but are not limited to, interviewing and selecting fellow applicants, providing didactic instruction, mentoring fellows, simulation exercises, completing the annual ACGME Faculty Survey, and participating on the program's Clinical Competency Committee, Program Evaluation Committee, and other GME committees.

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

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

[The Review Committee must specify the minimum number of core faculty and/or the core faculty-fellow ratio]

[The Review Committee may further specify requirements regarding dedicated time support for core faculty members]

[The Review Committee may specify requirements specific to associate program director(s)]

II.C. Program Coordinator

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

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

[The Review Committee may **must** further specify **minimum** dedicated time for the program coordinator]

~~Background and Intent: Twenty percent FTE is defined as one day per week. [If applicable, this Background and Intent will be included in the subspecialty-specific program requirements and the number will be modified to fit the level of support specified by the Review Committee]~~

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

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

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

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

The minimum required dedicated time and support specified in II.C.2.a) is inclusive of activities directly related to administration of the accredited program. It is understood that coordinators often have additional responsibilities, beyond those directly related to program administration, including, but not limited to, departmental administrative responsibilities, medical school clerkships, planning lectures that are not solely intended for the accredited program, and mandatory reporting for entities other than the ACGME. Assignment of these other responsibilities will necessitate consideration of allocation of additional support so as not to preclude the coordinator from devoting the time specified above solely to administrative activities that support the accredited program.

In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a minimum, recognizing that, depending on the unique needs of the program, additional support may be warranted.

431
432
433

II.D. Other Program Personnel

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

437
438 [The Review Committee may further specify]
439

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

440
441 **III. Fellow Appointments**

442
443 **III.A. Eligibility Criteria**

444
445 **III.A.1. Eligibility Requirements – Fellowship Programs**

446
447 [Review Committee to choose one of the following:]

448
449 **Option 1: All required clinical education for entry into ACGME-**
450 **accredited fellowship programs must be completed in an ACGME-**
451 **accredited residency program, an AOA-approved residency**
452 **program, a program with ACGME International (ACGME-I) Advanced**
453 **Specialty Accreditation, or a Royal College of Physicians and**
454 **Surgeons of Canada (RCPSC)-accredited or College of Family**
455 **Physicians of Canada (CFPC)-accredited residency program located**
456 **in Canada. ^(Core)**

457
458 **Option 2: All required clinical education for entry into ACGME-**
459 **accredited fellowship programs must be completed in an ACGME-**
460 **accredited residency program or an AOA-approved residency**
461 **program. ^(Core)**

462
463 **Background and Intent: Eligibility for ABMS or AOA Board certification may not be**
464 **satisfied by fellowship training. Applicants must be notified of this at the time of**
465 **application, as required in II.A.4.a).(9).**

466
467 **III.A.1.a) [If Review Committee selected Option 1 above:]**
468 **Fellowship programs must receive verification of each**
469 **entering fellow’s level of competence in the required field,**
470 **upon matriculation, using ACGME, ACGME-I, or CanMEDS**
471 **Milestones evaluations from the core residency program. ^(Core)**

472
473 **[If Review Committee selected Option 2 above:]**
474 **Fellowship programs must receive verification of each**
475 **entering fellow’s level of competence in the required field,**
upon matriculation, using ACGME Milestones evaluations from the core residency program. ^(Core)

- 476 III.A.1.b) [The Review Committee must further specify prerequisite
477 postgraduate clinical education]
478
- 479 III.A.1.c) Fellow Eligibility Exception
480
481 The Review Committee for _____ will allow the following
482 exception to the fellowship eligibility requirements:
483
484 [Note: Review Committees that selected Option 1 will decide
485 whether or not to allow this exception. This section will be
486 deleted for Review Committees that do not allow the
487 exception and for Review Committees that selected Option 2]
488
- 489 III.A.1.c).(1) An ACGME-accredited fellowship program may accept
490 an exceptionally qualified international graduate
491 applicant who does not satisfy the eligibility
492 requirements listed in III.A.1., but who does meet all of
493 the following additional qualifications and conditions:
494 (Core)
495
- 496 III.A.1.c).(1).(a) evaluation by the program director and
497 fellowship selection committee of the
498 applicant's suitability to enter the program,
499 based on prior training and review of the
500 summative evaluations of training in the core
501 specialty; and, (Core)
502
- 503 III.A.1.c).(1).(b) review and approval of the applicant's
504 exceptional qualifications by the GMEC; and,
505 (Core)
506
- 507 III.A.1.c).(1).(c) verification of Educational Commission for
508 Foreign Medical Graduates (ECFMG)
509 certification. (Core)
510
- 511 III.A.1.c).(2) Applicants accepted through this exception must have
512 an evaluation of their performance by the Clinical
513 Competency Committee within 12 weeks of
514 matriculation. (Core)
515

[If Review Committee allows the exception specified above:]
Background and Intent: An exceptionally qualified international graduate applicant has
 (1) completed a residency program in the core specialty outside the continental United States that was not accredited by the ACGME, AOA, ACGME-I, RCPSC or CFPC, and
 (2) demonstrated clinical excellence, in comparison to peers, throughout training.
 Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; and/or (c) demonstrated leadership during or after residency. Applicants being considered for these positions must be informed of the fact that their training may not lead to certification by ABMS member boards or AOA certifying boards.

In recognition of the diversity of medical education and training around the world, this early evaluation of clinical competence required for these applicants ensures they can provide quality and safe patient care. Any gaps in competence should be addressed as per policies for fellows already established by the program in partnership with the Sponsoring Institution.

516
517 **III.B.** The program director must not appoint more fellows than approved by the
518 Review Committee. ^(Core)
519

520 **III.B.1.** All complement increases must be approved by the Review
521 Committee. ^(Core)
522

523 [The Review Committee may further specify minimum complement
524 numbers]
525

526 **III.C.** Fellow Transfers
527

528 The program must obtain verification of previous educational experiences
529 and a summative competency-based performance evaluation prior to
530 acceptance of a transferring fellow, and Milestones evaluations upon
531 matriculation. ^(Core)
532

533 [The Review Committee may further specify]
534

535 **IV.** Educational Program
536

537 *The ACGME accreditation system is designed to encourage excellence and*
538 *innovation in graduate medical education regardless of the organizational*
539 *affiliation, size, or location of the program.*
540

541 *The educational program must support the development of knowledgeable, skillful*
542 *physicians who provide compassionate care.*
543

544 *In addition, the program is expected to define its specific program aims consistent*
545 *with the overall mission of its Sponsoring Institution, the needs of the community*
546 *it serves and that its graduates will serve, and the distinctive capabilities of*
547 *physicians it intends to graduate. While programs must demonstrate substantial*
548 *compliance with the Common and subspecialty-specific Program Requirements, it*
549 *is recognized that within this framework, programs may place different emphasis*
550 *on research, leadership, public health, etc. It is expected that the program aims*
551 *will reflect the nuanced program-specific goals for it and its graduates; for*
552 *example, it is expected that a program aiming to prepare physician-scientists will*
553 *have a different curriculum from one focusing on community health.*
554

555 **IV.A.** The curriculum must contain the following educational components: ^(Core)
556

557 **IV.A.1.** a set of program aims consistent with the Sponsoring Institution's
558 mission, the needs of the community it serves, and the desired
559 distinctive capabilities of its graduates; ^(Core)
560

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

563
564 IV.A.2. competency-based goals and objectives for each educational
565 experience designed to promote progress on a trajectory to
566 autonomous practice in their subspecialty. These must be
567 distributed, reviewed, and available to fellows and faculty members;
568 (Core)

569
570 IV.A.3. delineation of fellow responsibilities for patient care, progressive
571 responsibility for patient management, and graded supervision in
572 their subspecialty; (Core)

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

574
575 IV.A.4. structured educational activities beyond direct patient care; and,
576 (Core)
577

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

578
579 IV.A.5. advancement of fellows' knowledge of ethical principles
580 foundational to medical professionalism. (Core)

581
582 IV.B. ACGME Competencies
583

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

584
585 IV.B.1. The program must integrate the following ACGME Competencies
586 into the curriculum: (Core)

587
588 IV.B.1.a) Professionalism

589
590 Fellows must demonstrate a commitment to professionalism
591 and an adherence to ethical principles. (Core)

592
593
594

IV.B.1.b) Patient Care and Procedural Skills

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

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

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

[The Review Committee must further specify]

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)

[The Review Committee may further specify]

IV.B.1.c) Medical Knowledge

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

[The Review Committee must further specify]

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)

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

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

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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)

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 social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. ^(Core)

IV.C. Curriculum Organization and Fellow Experiences

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

[The Review Committee must further specify]

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

[The Review Committee may further specify]

[The Review Committee may specify required didactic and clinical experiences]

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

674 *quality improvement, population health, and/or teaching, while other*
675 *programs might choose to utilize more classic forms of biomedical*
676 *research as the focus for scholarship.*

677
678 **IV.D.1. Program Responsibilities**

679
680 **IV.D.1.a) The program must demonstrate evidence of scholarly**
681 **activities, consistent with its mission(s) and aims. ^(Core)**

682
683 [The Review Committee may further specify]

684
685 **IV.D.1.b) The program in partnership with its Sponsoring Institution,**
686 **must allocate adequate resources to facilitate fellow and**
687 **faculty involvement in scholarly activities. ^(Core)**

688
689 [The Review Committee may further specify]

690
691 **IV.D.2. Faculty Scholarly Activity**

692
693 **IV.D.2.a) Among their scholarly activity, programs must demonstrate**
694 **accomplishments in at least three of the following domains:**
695 **^(Core)**

- 696 • Research in basic science, education, translational
- 697 science, patient care, or population health
- 698 • Peer-reviewed grants
- 699 • Quality improvement and/or patient safety initiatives
- 700 • Systematic reviews, meta-analyses, review articles,
- 701 chapters in medical textbooks, or case reports
- 702 • Creation of curricula, evaluation tools, didactic
- 703 educational activities, or electronic educational
- 704 materials
- 705 • Contribution to professional committees, educational
- 706 organizations, or editorial boards
- 707 • Innovations in education

708
709
710 **IV.D.2.b) The program must demonstrate dissemination of scholarly**
711 **activity within and external to the program by the following**
712 **methods:**

713
714 [Review Committee will choose to require either IV.D.2.b).(1)
715 or both IV.D.2.b).(1) and IV.D.2.b).(2)]
716

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

differences in scholarship requirements between different specialties and between residencies and fellowships in the same specialty.

- 717
718 **IV.D.2.b).(1)** faculty participation in grand rounds, posters,
719 workshops, quality improvement presentations,
720 podium presentations, grant leadership, non-peer-
721 reviewed print/electronic resources, articles or
722 publications, book chapters, textbooks, webinars,
723 service on professional committees, or serving as a
724 journal reviewer, journal editorial board member, or
725 editor; ^{(Outcome)‡}
726
727 [The Review Committee may further specify]
728
729 **IV.D.2.b).(2)** peer-reviewed publication. ^(Outcome)
730
731 [The Review Committee may further specify]
732
733 **IV.D.3. Fellow Scholarly Activity**
734
735 [The Review Committee may further specify]
736
737 **IV.E. *Fellowship programs may assign fellows to engage in the independent***
738 ***practice of their core specialty during their fellowship program.***
739
740 **IV.E.1. If programs permit their fellows to utilize the independent practice**
741 **option, it must not exceed 20 percent of their time per week or 10**
742 **weeks of an academic year. ^(Core)**
743
744 [This section will be deleted for those Review Committees that
745 choose not to permit the independent practice option. For those that
746 choose to permit this option, the Review Committee may further
747 specify.]
748

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

- 749
750 **V. Evaluation**
751
752 **V.A. Fellow Evaluation**
753
754 **V.A.1. Feedback and Evaluation**
755

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower fellows to

provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

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

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

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

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

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

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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)

[The Review Committee may further specify]

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

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

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

V.A.1.b).(2) Longitudinal experiences such as continuity clinic in the context of other clinical responsibilities must be evaluated at least every three months and at completion. ^(Core)

- 775
776 **V.A.1.c)** The program must provide an objective performance
777 evaluation based on the Competencies and the subspecialty-
778 specific Milestones, and must: ^(Core)
779
- 780 **V.A.1.c).(1)** use multiple evaluators (e.g., faculty members, peers,
781 patients, self, and other professional staff members);
782 and, ^(Core)
783
- 784 **V.A.1.c).(2)** provide that information to the Clinical Competency
785 Committee for its synthesis of progressive fellow
786 performance and improvement toward unsupervised
787 practice. ^(Core)
788

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

- 789
790 **V.A.1.d)** The program director or their designee, with input from the
791 Clinical Competency Committee, must:
792
- 793 **V.A.1.d).(1)** meet with and review with each fellow their
794 documented semi-annual evaluation of performance,
795 including progress along the subspecialty-specific
796 Milestones. ^(Core)
797
- 798 **V.A.1.d).(2)** assist fellows in developing individualized learning
799 plans to capitalize on their strengths and identify areas
800 for growth; and, ^(Core)
801
- 802 **V.A.1.d).(3)** develop plans for fellows failing to progress, following
803 institutional policies and procedures. ^(Core)
804

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

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

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

- 805
806 **V.A.1.e)** At least annually, there must be a summative evaluation of
807 each fellow that includes their readiness to progress to the
808 next year of the program, if applicable. ^(Core)
809
- 810 **V.A.1.f)** The evaluations of a fellow's performance must be accessible
811 for review by the fellow. ^(Core)
812
- 813 **V.A.2.** Final Evaluation
814
- 815 **V.A.2.a)** The program director must provide a final evaluation for each
816 fellow upon completion of the program. ^(Core)
817
- 818 **V.A.2.a).(1)** The subspecialty-specific Milestones, and when
819 applicable the subspecialty-specific Case Logs, must
820 be used as tools to ensure fellows are able to engage
821 in autonomous practice upon completion of the
822 program. ^(Core)
823
- 824 **V.A.2.a).(2)** The final evaluation must:
825
- 826 **V.A.2.a).(2).(a)** become part of the fellow's permanent record
827 maintained by the institution, and must be
828 accessible for review by the fellow in
829 accordance with institutional policy; ^(Core)
830
- 831 **V.A.2.a).(2).(b)** verify that the fellow has demonstrated the
832 knowledge, skills, and behaviors necessary to
833 enter autonomous practice; ^(Core)
834
- 835 **V.A.2.a).(2).(c)** consider recommendations from the Clinical
836 Competency Committee; and, ^(Core)
837
- 838 **V.A.2.a).(2).(d)** be shared with the fellow upon completion of
839 the program. ^(Core)
840
- 841 **V.A.3.** A Clinical Competency Committee must be appointed by the
842 program director. ^(Core)
843
- 844 **V.A.3.a)** At a minimum the Clinical Competency Committee must
845 include three members, at least one of whom is a core faculty
846 member. Members must be faculty members from the same
847 program or other programs, or other health professionals
848 who have extensive contact and experience with the
849 program's fellows. ^(Core)

- 850
851 **V.A.3.b) The Clinical Competency Committee must:**
852
853 **V.A.3.b).(1) review all fellow evaluations at least semi-annually;**
854 **(Core)**
855
856 **V.A.3.b).(2) determine each fellow’s progress on achievement of**
857 **the subspecialty-specific Milestones; and, (Core)**
858
859 **V.A.3.b).(3) meet prior to the fellows’ semi-annual evaluations and**
860 **advise the program director regarding each fellow’s**
861 **progress. (Core)**
862
863 **V.B. Faculty Evaluation**
864
865 **V.B.1. The program must have a process to evaluate each faculty**
866 **member’s performance as it relates to the educational program at**
867 **least annually. (Core)**
868

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

- 869
870 **V.B.1.a) This evaluation must include a review of the faculty member’s**
871 **clinical teaching abilities, engagement with the educational**
872 **program, participation in faculty development related to their**
873 **skills as an educator, clinical performance, professionalism,**
874 **and scholarly activities. (Core)**
875
876 **V.B.1.b) This evaluation must include written, confidential evaluations**
877 **by the fellows. (Core)**
878
879 **V.B.2. Faculty members must receive feedback on their evaluations at least**
880 **annually. (Core)**
881

882 V.B.3. Results of the faculty educational evaluations should be
883 incorporated into program-wide faculty development plans. (Core)
884

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

885
886 V.C. Program Evaluation and Improvement
887

888 V.C.1. The program director must appoint the Program Evaluation
889 Committee to conduct and document the Annual Program
890 Evaluation as part of the program’s continuous improvement
891 process. (Core)
892

893 V.C.1.a) The Program Evaluation Committee must be composed of at
894 least two program faculty members, at least one of whom is a
895 core faculty member, and at least one fellow. (Core)
896

897 V.C.1.b) Program Evaluation Committee responsibilities must include:

898
899 V.C.1.b).(1) acting as an advisor to the program director, through
900 program oversight; (Core)
901

902 V.C.1.b).(2) review of the program’s self-determined goals and
903 progress toward meeting them; (Core)
904

905 V.C.1.b).(3) guiding ongoing program improvement, including
906 development of new goals, based upon outcomes;
907 and, (Core)
908

909 V.C.1.b).(4) review of the current operating environment to identify
910 strengths, challenges, opportunities, and threats as
911 related to the program’s mission and aims. (Core)
912

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

913
914 V.C.1.c) The Program Evaluation Committee should consider the
915 following elements in its assessment of the program:
916

917 V.C.1.c).(1) curriculum; (Core)
918

919 V.C.1.c).(2) outcomes from prior Annual Program Evaluation(s);
920 (Core)

921		
922	V.C.1.c).(3)	ACGME letters of notification, including citations, Areas for Improvement, and comments; ^(Core)
923		
924		
925	V.C.1.c).(4)	quality and safety of patient care; ^(Core)
926		
927	V.C.1.c).(5)	aggregate fellow and faculty:
928		
929	V.C.1.c).(5).(a)	well-being; ^(Core)
930		
931	V.C.1.c).(5).(b)	recruitment and retention; ^(Core)
932		
933	V.C.1.c).(5).(c)	workforce diversity; ^(Core)
934		
935	V.C.1.c).(5).(d)	engagement in quality improvement and patient safety; ^(Core)
936		
937		
938	V.C.1.c).(5).(e)	scholarly activity; ^(Core)
939		
940	V.C.1.c).(5).(f)	ACGME Resident/Fellow and Faculty Surveys (where applicable); and, ^(Core)
941		
942		
943	V.C.1.c).(5).(g)	written evaluations of the program. ^(Core)
944		
945	V.C.1.c).(6)	aggregate fellow:
946		
947	V.C.1.c).(6).(a)	achievement of the Milestones; ^(Core)
948		
949	V.C.1.c).(6).(b)	in-training examinations (where applicable); ^(Core)
950		
951		
952	V.C.1.c).(6).(c)	board pass and certification rates; and, ^(Core)
953		
954	V.C.1.c).(6).(d)	graduate performance. ^(Core)
955		
956	V.C.1.c).(7)	aggregate faculty:
957		
958	V.C.1.c).(7).(a)	evaluation; and, ^(Core)
959		
960	V.C.1.c).(7).(b)	professional development ^(Core)
961		
962	V.C.1.d)	The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. ^(Core)
963		
964		
965		
966	V.C.1.e)	The annual review, including the action plan, must:
967		
968	V.C.1.e).(1)	be distributed to and discussed with the members of the teaching faculty and the fellows; and, ^(Core)
969		
970		
971	V.C.1.e).(2)	be submitted to the DIO. ^(Core)

972
973 **V.C.2.** The program must participate in a Self-Study prior to its 10-Year
974 Accreditation Site Visit. ^(Core)

975
976 **V.C.2.a)** A summary of the Self-Study must be submitted to the DIO.
977 ^(Core)
978

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

979
980 **V.C.3.** *One goal of ACGME-accredited education is to educate physicians*
981 *who seek and achieve board certification. One measure of the*
982 *effectiveness of the educational program is the ultimate pass rate.*

983
984 *The program director should encourage all eligible program*
985 *graduates to take the certifying examination offered by the*
986 *applicable American Board of Medical Specialties (ABMS) member*
987 *board or American Osteopathic Association (AOA) certifying board.*
988

989 **V.C.3.a)** For subspecialties in which the ABMS member board and/or
990 AOA certifying board offer(s) an annual written exam, in the
991 preceding three years, the program's aggregate pass rate of
992 those taking the examination for the first time must be higher
993 than the bottom fifth percentile of programs in that
994 subspecialty. ^(Outcome)
995

996 **V.C.3.b)** For subspecialties in which the ABMS member board and/or
997 AOA certifying board offer(s) a biennial written exam, in the
998 preceding six years, the program's aggregate pass rate of
999 those taking the examination for the first time must be higher
1000 than the bottom fifth percentile of programs in that
1001 subspecialty. ^(Outcome)
1002

1003 **V.C.3.c)** For subspecialties in which the ABMS member board and/or
1004 AOA certifying board offer(s) an annual oral exam, in the
1005 preceding three years, the program's aggregate pass rate of
1006 those taking the examination for the first time must be higher
1007 than the bottom fifth percentile of programs in that
1008 subspecialty. ^(Outcome)
1009

1010 **V.C.3.d)** For subspecialties in which the ABMS member board and/or
1011 AOA certifying board offer(s) a biennial oral exam, in the

1012 preceding six years, the program's aggregate pass rate of
1013 those taking the examination for the first time must be higher
1014 than the bottom fifth percentile of programs in that
1015 subspecialty. ^(Outcome)

1016
1017 **V.C.3.e)** For each of the exams referenced in V.C.3.a)-d), any program
1018 whose graduates over the time period specified in the
1019 requirement have achieved an 80 percent pass rate will have
1020 met this requirement, no matter the percentile rank of the
1021 program for pass rate in that subspecialty. ^(Outcome)
1022

Background and Intent: Setting a single standard for pass rate that works across subspecialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are subspecialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

1023
1024 **V.C.3.f)** Programs must report, in ADS, board certification status
1025 annually for the cohort of board-eligible fellows that
1026 graduated seven years earlier. ^(Core)
1027

Background and Intent: It is essential that fellowship programs demonstrate knowledge and skill transfer to their fellows. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from fellowship graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

1028
1029 **VI. The Learning and Working Environment**
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Fellowship education must occur in the context of a learning and working environment that emphasizes the following principles:

- *Excellence in the safety and quality of care rendered to patients by fellows today*

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

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

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

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

VI.A.1. Patient Safety and Quality Improvement

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

1064
1065 ***Fellows must demonstrate the ability to analyze the care they***
1066 ***provide, understand their roles within health care teams, and play an***
1067 ***active role in system improvement processes. Graduating fellows***
1068 ***will apply these skills to critique their future unsupervised practice***
1069 ***and effect quality improvement measures.***

1070
1071 ***It is necessary for fellows and faculty members to consistently work***
1072 ***in a well-coordinated manner with other health care professionals to***
1073 ***achieve organizational patient safety goals.***

1074
1075 **VI.A.1.a) Patient Safety**

1076
1077 **VI.A.1.a).(1) Culture of Safety**

1078 ***A culture of safety requires continuous identification***
1079 ***of vulnerabilities and a willingness to transparently***
1080 ***deal with them. An effective organization has formal***
1081 ***mechanisms to assess the knowledge, skills, and***
1082 ***attitudes of its personnel toward safety in order to***
1083 ***identify areas for improvement.***

1084
1085
1086 **VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows**
1087 **must actively participate in patient safety**
1088 **systems and contribute to a culture of safety.**
1089 **(Core)**

1090
1091 **VI.A.1.a).(1).(b) The program must have a structure that**
1092 **promotes safe, interprofessional, team-based**
1093 **care. (Core)**

1094
1095 **VI.A.1.a).(2) Education on Patient Safety**

1096
1097 **Programs must provide formal educational activities**
1098 **that promote patient safety-related goals, tools, and**
1099 **techniques. (Core)**

1100

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

1101

1102 **[The Review Committee may further specify]**

1103

1104 **VI.A.1.a).(3) Patient Safety Events**

1105 ***Reporting, investigation, and follow-up of adverse***
1106 ***events, near misses, and unsafe conditions are pivotal***
1107 ***mechanisms for improving patient safety, and are***
1108 ***essential for the success of any patient safety***
1109 ***program. Feedback and experiential learning are***
1110 ***essential to developing true competence in the ability***
1111 ***to identify causes and institute sustainable systems-***
1112

based changes to ameliorate patient safety vulnerabilities.

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1115
1116 **VI.A.1.a).(3).(a)** Residents, fellows, faculty members, and other
1117 clinical staff members must:

1118
1119 **VI.A.1.a).(3).(a).(i)** know their responsibilities in reporting
1120 patient safety events at the clinical site;
1121 (Core)

1122
1123 **VI.A.1.a).(3).(a).(ii)** know how to report patient safety
1124 events, including near misses, at the
1125 clinical site; and, (Core)

1126
1127 **VI.A.1.a).(3).(a).(iii)** be provided with summary information
1128 of their institution's patient safety
1129 reports. (Core)

1130
1131 **VI.A.1.a).(3).(b)** Fellows must participate as team members in
1132 real and/or simulated interprofessional clinical
1133 patient safety activities, such as root cause
1134 analyses or other activities that include
1135 analysis, as well as formulation and
1136 implementation of actions. (Core)

1137
1138 **VI.A.1.a).(4)** Fellow Education and Experience in Disclosure of
1139 Adverse Events

1140
1141 ***Patient-centered care requires patients, and when***
1142 ***appropriate families, to be apprised of clinical***
1143 ***situations that affect them, including adverse events.***
1144 ***This is an important skill for faculty physicians to***
1145 ***model, and for fellows to develop and apply.***

1146
1147 **VI.A.1.a).(4).(a)** All fellows must receive training in how to
1148 disclose adverse events to patients and
1149 families. (Core)

1150
1151 **VI.A.1.a).(4).(b)** Fellows should have the opportunity to
1152 participate in the disclosure of patient safety
1153 events, real or simulated. (Detail)†

1154
1155 **VI.A.1.b)** Quality Improvement

1156
1157 **VI.A.1.b).(1)** Education in Quality Improvement

1158
1159 ***A cohesive model of health care includes quality-***
1160 ***related goals, tools, and techniques that are necessary***
1161 ***in order for health care professionals to achieve***
1162 ***quality improvement goals.***
1163

1164	VI.A.1.b).(1).(a)	Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities. ^(Core)
1165		
1166		
1167		
1168	VI.A.1.b).(2)	Quality Metrics
1169		
1170		<i>Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.</i>
1171		
1172		
1173		
1174	VI.A.1.b).(2).(a)	Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. ^(Core)
1175		
1176		
1177		
1178	VI.A.1.b).(3)	Engagement in Quality Improvement Activities
1179		
1180		<i>Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.</i>
1181		
1182		
1183		
1184	VI.A.1.b).(3).(a)	Fellows must have the opportunity to participate in interprofessional quality improvement activities. ^(Core)
1185		
1186		
1187		
1188	VI.A.1.b).(3).(a).(i)	This should include activities aimed at reducing health care disparities. ^(Detail)
1189		
1190		
1191		[The Review Committee may further specify under any requirement in VI.A.1.b)-VI.A.1.b).(3).(a).(i)]
1192		
1193		
1194	VI.A.2.	Supervision and Accountability
1195		
1196	VI.A.2.a)	<i>Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.</i>
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1204		
1205		<i>Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.</i>
1206		
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1211	VI.A.2.a).(1)	Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is
1212		
1213		
1214		

1215 responsible and accountable for the patient's care.
1216 (Core)

1217
1218 VI.A.2.a).(1).(a) This information must be available to fellows,
1219 faculty members, other members of the health
1220 care team, and patients. (Core)

1221
1222 VI.A.2.a).(1).(b) Fellows and faculty members must inform each
1223 patient of their respective roles in that patient's
1224 care when providing direct patient care. (Core)

1225
1226 VI.A.2.b) *Supervision may be exercised through a variety of methods.*
1227 *For many aspects of patient care, the supervising physician*
1228 *may be a more advanced fellow. Other portions of care*
1229 *provided by the fellow can be adequately supervised by the*
1230 *appropriate availability of the supervising faculty member or*
1231 *fellow, either on site or by means of telecommunication*
1232 *technology. Some activities require the physical presence of*
1233 *the supervising faculty member. In some circumstances,*
1234 *supervision may include post-hoc review of fellow-delivered*
1235 *care with feedback.*

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

1237
1238 VI.A.2.b).(1) The program must demonstrate that the appropriate
1239 level of supervision in place for all fellows is based on
1240 each fellow's level of training and ability, as well as
1241 patient complexity and acuity. Supervision may be
1242 exercised through a variety of methods, as appropriate
1243 to the situation. (Core)

1244
1245 [The Review Committee may specify which
1246 activities require different levels of
1247 supervision.]

1248
1249 VI.A.2.b).(2) The program must define when physical presence of a
1250 supervising physician is required. (Core)

1251
1252 VI.A.2.c) Levels of Supervision

1253
1254 To promote appropriate fellow supervision while providing
1255 for graded authority and responsibility, the program must use
1256 the following classification of supervision: (Core)

1257		
1258	VI.A.2.c).(1)	Direct Supervision:
1259		
1260	VI.A.2.c).(1).(a)	the supervising physician is physically present
1261		with the fellow during the key portions of the
1262		patient interaction; or, ^(Core)
1263		
1264		[The Review Committee may further specify]
1265		
1266	VI.A.2.c).(1).(b)	the supervising physician and/or patient is not
1267		physically present with the fellow and the
1268		supervising physician is concurrently
1269		monitoring the patient care through appropriate
1270		telecommunication technology. ^(Core)
1271		
1272		[The Review Committee may further
1273		specify]
1274		
1275		[The RC may choose not to permit
1276		VI.A.2.c).(1).(b)]
1277		
1278	VI.A.2.c).(2)	Indirect Supervision: the supervising physician is not
1279		providing physical or concurrent visual or audio
1280		supervision but is immediately available to the fellow
1281		for guidance and is available to provide appropriate
1282		direct supervision. ^(Core)
1283		
1284	VI.A.2.c).(3)	Oversight – the supervising physician is available to
1285		provide review of procedures/encounters with
1286		feedback provided after care is delivered. ^(Core)
1287		
1288	VI.A.2.d)	The privilege of progressive authority and responsibility,
1289		conditional independence, and a supervisory role in patient
1290		care delegated to each fellow must be assigned by the
1291		program director and faculty members. ^(Core)
1292		
1293	VI.A.2.d).(1)	The program director must evaluate each fellow’s
1294		abilities based on specific criteria, guided by the
1295		Milestones. ^(Core)
1296		
1297	VI.A.2.d).(2)	Faculty members functioning as supervising
1298		physicians must delegate portions of care to fellows
1299		based on the needs of the patient and the skills of
1300		each fellow. ^(Core)
1301		
1302	VI.A.2.d).(3)	Fellows should serve in a supervisory role to junior
1303		fellows and residents in recognition of their progress
1304		toward independence, based on the needs of each
1305		patient and the skills of the individual resident or
1306		fellow. ^(Detail)
1307		

1308 VI.A.2.e) Programs must set guidelines for circumstances and events
1309 in which fellows must communicate with the supervising
1310 faculty member(s). ^(Core)

1311
1312 VI.A.2.e).(1) Each fellow must know the limits of their scope of
1313 authority, and the circumstances under which the
1314 fellow is permitted to act with conditional
1315 independence. ^(Outcome)
1316

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

1317
1318 VI.A.2.f) Faculty supervision assignments must be of sufficient
1319 duration to assess the knowledge and skills of each fellow
1320 and to delegate to the fellow the appropriate level of patient
1321 care authority and responsibility. ^(Core)
1322

1323 VI.B. Professionalism

1324
1325 VI.B.1. Programs, in partnership with their Sponsoring Institutions, must
1326 educate fellows and faculty members concerning the professional
1327 responsibilities of physicians, including their obligation to be
1328 appropriately rested and fit to provide the care required by their
1329 patients. ^(Core)
1330

1331 VI.B.2. The learning objectives of the program must:

1332
1333 VI.B.2.a) be accomplished through an appropriate blend of supervised
1334 patient care responsibilities, clinical teaching, and didactic
1335 educational events; ^(Core)
1336

1337 VI.B.2.b) be accomplished without excessive reliance on fellows to
1338 fulfill non-physician obligations; and, ^(Core)
1339

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

1340
1341 VI.B.2.c) ensure manageable patient care responsibilities. ^(Core)
1342

1343 [The Review Committee may further specify]
1344

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

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- 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)
 - VI.B.4.** Fellows and faculty members must demonstrate an understanding of their personal role in the:
 - VI.B.4.a)** provision of patient- and family-centered care; ^(Outcome)
 - VI.B.4.b)** safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; ^(Outcome)

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

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1361
- VI.B.4.c)** assurance of their fitness for work, including: ^(Outcome)

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

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- VI.B.4.c).(1)** management of their time before, during, and after clinical assignments; and, ^(Outcome)
 - VI.B.4.c).(2)** recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. ^(Outcome)
 - VI.B.4.d)** commitment to lifelong learning; ^(Outcome)
 - VI.B.4.e)** monitoring of their patient care performance improvement indicators; and, ^(Outcome)
 - VI.B.4.f)** accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. ^(Outcome)

1378 VI.B.5. All fellows and faculty members must demonstrate responsiveness
1379 to patient needs that supersedes self-interest. This includes the
1380 recognition that under certain circumstances, the best interests of
1381 the patient may be served by transitioning that patient's care to
1382 another qualified and rested provider. (Outcome)
1383

1384 VI.B.6. Programs, in partnership with their Sponsoring Institutions, must
1385 provide a professional, equitable, respectful, and civil environment
1386 that is free from discrimination, sexual and other forms of
1387 harassment, mistreatment, abuse, or coercion of students, fellows,
1388 faculty, and staff. (Core)
1389

1390 VI.B.7. Programs, in partnership with their Sponsoring Institutions, should
1391 have a process for education of fellows and faculty regarding
1392 unprofessional behavior and a confidential process for reporting,
1393 investigating, and addressing such concerns. (Core)
1394

1395 VI.C. Well-Being

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1397 *Psychological, emotional, and physical well-being are critical in the*
1398 *development of the competent, caring, and resilient physician and require*
1399 *proactive attention to life inside and outside of medicine. Well-being*
1400 *requires that physicians retain the joy in medicine while managing their*
1401 *own real-life stresses. Self-care and responsibility to support other*
1402 *members of the health care team are important components of*
1403 *professionalism; they are also skills that must be modeled, learned, and*
1404 *nurtured in the context of other aspects of fellowship training.*
1405

1406 *Fellows and faculty members are at risk for burnout and depression.*
1407 *Programs, in partnership with their Sponsoring Institutions, have the same*
1408 *responsibility to address well-being as other aspects of resident*
1409 *competence. Physicians and all members of the health care team share*
1410 *responsibility for the well-being of each other. For example, a culture which*
1411 *encourages covering for colleagues after an illness without the expectation*
1412 *of reciprocity reflects the ideal of professionalism. A positive culture in a*
1413 *clinical learning environment models constructive behaviors, and prepares*
1414 *fellows with the skills and attitudes needed to thrive throughout their*
1415 *careers.*
1416

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

~~As these efforts evolve, information will be shared with programs seeking to develop and/or strengthen their own well-being initiatives. The ACGME also created a repository for well-being materials, assessments, presentations, and more on the [Well-Being Tools](#)~~

[and Resources page](#) in Learn at ACGME for programs seeking to develop or strengthen their own well-being initiatives. In addition, there are many activities that programs can utilize implement now to assess and support physician well-being. These include the distribution and analysis of culture of safety surveys, ensuring the availability of counseling services, and paying attention to the safety of the entire health care team.

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

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

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

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

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

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

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- VI.C.1.e)** attention to fellow and faculty member burnout, depression, and substance use disorder. The program, in partnership with its Sponsoring Institution, must educate faculty members and

1448 fellows in identification of the symptoms of burnout,
1449 depression, and substance use disorder, including means to
1450 assist those who experience these conditions. Fellows and
1451 faculty members must also be educated to recognize those
1452 symptoms in themselves and how to seek appropriate care.
1453 The program, in partnership with its Sponsoring Institution,
1454 must: ^(Core)
1455

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance use disorder. Materials and more information are available in Learn at ACGME (<https://dl.acgme.org/pages/well-being-tools-resources>), on the Physician Well-being section of the ACGME website (<http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being>).

1456 VI.C.1.e).(1) encourage fellows and faculty members to alert the
1457 program director or other designated personnel or
1458 programs when they are concerned that another
1459 fellow, resident, or faculty member may be displaying
1460 signs of burnout, depression, a substance use
1461 disorder, suicidal ideation, or potential for violence;
1462 ^(Core)
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Background and Intent: Individuals experiencing burnout, depression, substance use disorder, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that fellows and faculty members are able to report their concerns when another fellow or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Fellows and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

1465 VI.C.1.e).(2) provide access to appropriate tools for self-screening;
1466 and, ^(Core)
1467
1468 VI.C.1.e).(3) provide access to confidential, affordable mental
1469 health assessment, counseling, and treatment,
1470 including access to urgent and emergent care 24
1471 hours a day, seven days a week. ^(Core)
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1473

Background and Intent: The intent of this requirement is to ensure that fellows have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health

issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement.

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

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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 parental leave. Each program must allow an appropriate length of absence for fellows unable to perform their patient care responsibilities. ^(Core)

VI.C.2.a) The program must have policies and procedures in place to ensure coverage 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)

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

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VI.D. Fatigue Mitigation

VI.D.1. Programs must:

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

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

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

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

This requirement emphasizes the importance of adequate rest before and after clinical responsibilities. Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active

to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

- 1503
1504 **VI.D.2.** Each program must ensure continuity of patient care, consistent
1505 with the program’s policies and procedures referenced in VI.C.2–
1506 VI.C.2.b), in the event that a fellow may be unable to perform their
1507 patient care responsibilities due to excessive fatigue. ^(Core)
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1509 **VI.D.3.** The program, in partnership with its Sponsoring Institution, must
1510 ensure adequate sleep facilities and safe transportation options for
1511 fellows who may be too fatigued to safely return home. ^(Core)
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1513 **VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care**
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1515 **VI.E.1. Clinical Responsibilities**
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1517 The clinical responsibilities for each fellow must be based on PGY
1518 level, patient safety, fellow ability, severity and complexity of patient
1519 illness/condition, and available support services. ^(Core)
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1521 [Optimal clinical workload may be further specified by each Review
1522 Committee]
1523

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

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1525 **VI.E.2. Teamwork**
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1527 Fellows must care for patients in an environment that maximizes
1528 communication. This must include the opportunity to work as a
1529 member of effective interprofessional teams that are appropriate to
1530 the delivery of care in the subspecialty and larger health system.
1531 ^(Core)
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1533 [The Review Committee may further specify]
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1535 **VI.E.3. Transitions of Care**
1536
1537 **VI.E.3.a)** Programs must design clinical assignments to optimize
1538 transitions in patient care, including their safety, frequency,
1539 and structure. ^(Core)
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- 1541 VI.E.3.b) Programs, in partnership with their Sponsoring Institutions,
 1542 must ensure and monitor effective, structured hand-over
 1543 processes to facilitate both continuity of care and patient
 1544 safety. ^(Core)
 1545
- 1546 VI.E.3.c) Programs must ensure that fellows are competent in
 1547 communicating with team members in the hand-over process.
 1548 ^(Outcome)
 1549
- 1550 VI.E.3.d) Programs and clinical sites must maintain and communicate
 1551 schedules of attending physicians and fellows currently
 1552 responsible for care. ^(Core)
 1553
- 1554 VI.E.3.e) Each program must ensure continuity of patient care,
 1555 consistent with the program’s policies and procedures
 1556 referenced in VI.C.2-VI.C.2.b), in the event that a fellow may
 1557 be unable to perform their patient care responsibilities due to
 1558 excessive fatigue or illness, or family emergency. ^(Core)
 1559
- 1560 VI.F. Clinical Experience and Education
 1561
 1562 *Programs, in partnership with their Sponsoring Institutions, must design*
 1563 *an effective program structure that is configured to provide fellows with*
 1564 *educational and clinical experience opportunities, as well as reasonable*
 1565 *opportunities for rest and personal activities.*
 1566

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

- 1567
- 1568 VI.F.1. Maximum Hours of Clinical and Educational Work per Week
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 1570 Clinical and educational work hours must be limited to no more than
 1571 80 hours per week, averaged over a four-week period, inclusive of all
 1572 in-house clinical and educational activities, clinical work done from
 1573 home, and all moonlighting. ^(Core)
 1574

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

Scheduling
 While the ACGME acknowledges that, on rare occasions, a fellow may work in excess of 80 hours in a given week, all programs and fellows utilizing this flexibility will be required to adhere to the 80-hour maximum weekly limit when averaged over a four-

week period. Programs that regularly schedule fellows to work 80 hours per week and still permit fellows to remain beyond their scheduled work period are likely to exceed the 80-hour maximum, which would not be in substantial compliance with the requirement. These programs should adjust schedules so that fellows are scheduled to work fewer than 80 hours per week, which would allow fellows to remain beyond their scheduled work period when needed without violating the 80-hour requirement. Programs may wish to consider using night float and/or making adjustments to the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.

Oversight

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

Work from Home

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

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

are structured to ensure that fellows are not working in excess of 80 hours per week, averaged over four weeks.

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VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) The program must design an effective program structure that is configured to provide fellows with educational opportunities, as well as reasonable opportunities for rest and personal well-being. ^(Core)

VI.F.2.b) Fellows should have eight hours off between scheduled clinical work and education periods. ^(Detail)

VI.F.2.b).(1) There may be circumstances when fellows choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. ^(Detail)

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

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

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

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

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and fellow needs. It is strongly recommended that fellows' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some fellows may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide fellows with a weekend, or two

consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes fellow well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as “one (1) continuous 24-hour period free from all administrative, clinical, and educational activities.”

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

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

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

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

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

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

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

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

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

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

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

Background and Intent: This requirement is intended to provide fellows with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a fellow may remain to attend a conference, or return for a conference later in

the day, only if the decision is made voluntarily. Fellows must not be required to stay. Programs allowing fellows to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the fellow and that fellows are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

- 1637
1638 VI.F.4.c) A Review Committee may grant rotation-specific exceptions
1639 for up to 10 percent or a maximum of 88 clinical and
1640 educational work hours to individual programs based on a
1641 sound educational rationale.
1642
1643 VI.F.4.c).(1) In preparing a request for an exception, the program
1644 director must follow the clinical and educational work
1645 hour exception policy from the *ACGME Manual of*
1646 *Policies and Procedures.* ^(Core)
1647
1648 VI.F.4.c).(2) Prior to submitting the request to the Review
1649 Committee, the program director must obtain approval
1650 from the Sponsoring Institution's GMEC and DIO. ^(Core)
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Background and Intent: The provision for exceptions for up to 88 hours per week has been modified to specify that exceptions may be granted for specific rotations if the program can justify the increase based on criteria specified by the Review Committee. As in the past, Review Committees may opt not to permit exceptions. The underlying philosophy for this requirement is that while it is expected that all fellows should be able to train within an 80-hour work week, it is recognized that some programs may include rotations with alternate structures based on the nature of the specialty. DIO/GMEC approval is required before the request will be considered by the Review Committee.

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1653 VI.F.5. Moonlighting
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1655 VI.F.5.a) Moonlighting must not interfere with the ability of the fellow
1656 to achieve the goals and objectives of the educational
1657 program, and must not interfere with the fellow's fitness for
1658 work nor compromise patient safety. ^(Core)
1659
1660 VI.F.5.b) Time spent by fellows in internal and external moonlighting
1661 (as defined in the ACGME Glossary of Terms) must be
1662 counted toward the 80-hour maximum weekly limit. ^(Core)
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Background and Intent: For additional clarification of the expectations related to moonlighting, please refer to the Common Program Requirement FAQs (available at <http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements>).

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1665 VI.F.6. In-House Night Float
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1667 Night float must occur within the context of the 80-hour and one-
1668 day-off-in-seven requirements. ^(Core)
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[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

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

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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)

VI.F.8. At-Home Call

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)

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)

VI.F.8.b) Fellows are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. ^(Detail)

[The Review Committee may further specify under any requirement in VI.F.-VI.F.8.b)]

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

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

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

1706 †**Detail Requirements:** Statements that describe a specific structure, resource, or process, for
1707 achieving compliance with a Core Requirement. Programs and sponsoring institutions in
1708 substantial compliance with the Outcome Requirements may utilize alternative or innovative
1709 approaches to meet Core Requirements.

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1711 ‡**Outcome Requirements:** Statements that specify expected measurable or observable
1712 attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their
1713 graduate medical education.

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1715 **Osteopathic Recognition**

1716 For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition
1717 Requirements also apply (www.acgme.org/OsteopathicRecognition).