



**Accreditation Council for
Graduate Medical Education**

**ACGME Program Requirements for
Graduate Medical Education
in Anesthesiology Critical Care Medicine**

ACGME-approved: September 29, 2013; effective: July 1, 2014

Revised Common Program Requirements effective: July 1, 2015

Revised Common Program Requirements effective: July 1, 2016

At its May 28, 2015 meeting, the Review Committee for Anesthesiology voted to allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A. Thus, Requirement III.A.3. has been revised.

Revised Common Program Requirements effective: July 1, 2017

ACGME Program Requirements for Graduate Medical Education in Anesthesiology Critical Care Medicine

One-year Common Program Requirements are in **BOLD**

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

Introduction

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

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

Int.B. An anesthesiology critical care medicine fellowship provides advanced knowledge, skills, and clinical experiences in critical care medicine to foster the practice of multidisciplinary critical care, including both medical and surgical critical care medicine.

The subspecialty of anesthesiology critical care medicine is devoted to the acute and long-term care of critically-ill patients with a wide variety of medical and surgical conditions, including multiple organ system derangements. The overall goals of education in anesthesiology critical care medicine is to produce physicians capable of working in any adult critical care unit and providing for the continuum of care within the intensive care unit and other hospital units, such as transitional care units designed to provide care for critically-ill patients.

Int.C. The educational program in anesthesiology critical care medicine must be 12 months in length. ^(Core)

I. Institutions

I.A. Sponsoring Institution

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

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

I.A.1. The sponsoring institution must also sponsor Accreditation Council for Graduate Medical Education (ACGME)-accredited graduate education programs in anesthesiology, internal medicine, and surgery. (Core)

I.A.2. When the institution sponsors more than one critical care program, it must coordinate interdisciplinary requirements to ensure that fellows meet the specific critical care medicine fellowship program requirements and criteria of their primary specialties (anesthesiology, internal medicine, surgery, or any other primary specialty that supports education and/or certification in critical care medicine). (Detail)

I.B. Participating Sites

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

The PLA should:

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

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

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

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

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS). (Core)

II. Program Personnel and Resources

II.A. Program Director

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

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

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

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

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

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

II.A.2.c).(1) The program director must have privileges to practice critical care medicine and procedures relevant to the practice of critical care medicine. (Core)

II.A.2.d) current appointment as a faculty member in the Department of Anesthesiology; (Core)

II.A.2.e) demonstrated ongoing academic achievements with appropriate dissemination, including publications in peer-reviewed journals, the development of educational programs, or the conduct of research; and, (Core)

II.A.2.f) post-residency or fellowship experience in the care of critically-ill patients. (Core)

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

The program director must:

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

II.A.3.b) be familiar with and oversee compliance with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures; (Detail)

- II.A.3.c) obtain review and approval of the sponsoring institution's GMC/DIO before submitting information or requests to the ACGME, including: ^(Core)**
- II.A.3.c).(1) all applications for ACGME accreditation of new programs; ^(Detail)**
 - II.A.3.c).(2) changes in fellow complement; ^(Detail)**
 - II.A.3.c).(3) major changes in program structure or length of training; ^(Detail)**
 - II.A.3.c).(4) progress reports requested by the Review Committee; ^(Detail)**
 - II.A.3.c).(5) requests for increases or any change to fellow duty hours; ^(Detail)**
 - II.A.3.c).(6) voluntary withdrawals of ACGME-accredited programs; ^(Detail)**
 - II.A.3.c).(7) requests for appeal of an adverse action; and, ^(Detail)**
 - II.A.3.c).(8) appeal presentations to a Board of Appeal or the ACGME. ^(Detail)**
- II.A.3.d) obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses: ^(Detail)**
- II.A.3.d).(1) program citations, and/or, ^(Detail)**
 - II.A.3.d).(2) request for changes in the program that would have significant impact, including financial, on the program or institution. ^(Detail)**
- II.A.3.e) devote a minimum of 50 percent of his or her time to clinical, educational, administrative, and academic activities in critical care medicine; ^(Core)**
- II.A.3.f) with input from the faculty, prepare and comply with written goals for the program; ^(Detail)**
- II.A.3.g) ensure that the program has written policies regarding substance abuse, fatigue, and duty hour expectations; ^(Detail)**
- II.A.3.h) collaborate with the core anesthesiology program director to clearly define and differentiate the lines of responsibility and clinical competencies expected of the anesthesiology core residents and the critical care fellows; ^(Detail)**

- II.A.3.i) ensure that the fellowship is coordinated with and does not compromise any of the requirements of the core residency in anesthesiology; and, ^(Detail)
- II.A.3.j) provide clinical supervision and teach fellows in one or more of the critical care units. ^(Detail)

II.B. Faculty

- II.B.1. There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows. ^(Core)**
- II.B.2. The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in the education of fellows. ^(Core)**
- II.B.3. The physician faculty must have current certification in the subspecialty by the American Board of Anesthesiology, or possess qualifications judged acceptable to the Review Committee. ^(Core)**
- II.B.3.a) Other qualifications that are acceptable to the Review Committee include certification in critical care medicine or its affiliated subspecialties by a medical or surgical board of the American Board of Medical Specialties (ABMS). ^(Core)
- II.B.4. The physician faculty must possess current medical licensure and appropriate medical staff appointment. ^(Core)**
- II.B.5. The physician faculty must include at least two FTE anesthesiologists with certification in critical care medicine or equivalent credentials. ^(Core)
- II.B.5.a) For programs with four or more fellows, there must be at least one FTE faculty member for every two fellows. ^(Core)
- II.B.6. Each faculty member participating in the fellowship must demonstrate ongoing academic achievements appropriate to anesthesiology critical care medicine, including publications, the development of the educational program, or the conduct of research. ^(Core)
- II.B.7. Faculty members with education and certification in other specialties, including diagnostic radiology, emergency medicine, internal medicine and its subspecialties, neurological surgery, neurology, obstetrics and gynecology, pathology, pediatrics, and surgery and its subspecialties, should participate in the program. ^(Detail)
- II.B.8. A critical care faculty member who is an anesthesiologist (program director or other) must function as the medical director or co-medical director of one or more of the critical care units in which the majority of fellows' clinical education is required to take place. ^(Core)

II.C. Other Program Personnel

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

- II.C.1. Health care personnel, including nurses with qualifications and experience in critical care medicine, critical care nurse practitioners when available, pharmacists, respiratory therapists, nutritionists, and case managers, must participate in the care of patients to optimize the multidisciplinary nature of the program. ^(Detail)

II.D. Resources

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

- II.D.1. The patient population available to the program must include a wide variety of clinical problems necessary for the development of broad-based clinical expertise in clinical care, the development of judgment required for a specialist across medical and surgical critical care medicine, and the opportunity to coordinate care across specialties. ^(Core)
- II.D.1.a) The patient population should include both adult and pediatric patients representing a wide variety of clinical problems, including congenital medical and surgical conditions. ^(Detail)
- II.D.2. The program must have facilities and space to support the educational needs of the fellows, including meeting space, conference space, space for academic activities, and access to computers. ^(Core)
- II.D.3. Education in anesthesiology critical care medicine must occur principally in areas of the hospital commonly characterized as intensive care units (ICUs) or transitional care units, such as multidisciplinary, surgical, medical, pulmonary, coronary care, neurology, neonatal and pediatric, high-risk pregnancy, neurosurgical, trauma, and burn units. ^(Core)
- II.D.3.a) There must be an average daily census of at least five patients per fellow during assignments to critical care units. ^(Detail)
- II.D.4. There must be readily available facilities to provide laboratory tests pertinent to care of critically-ill patients with multiple organ system derangements consistent with quality assurance and quality control requirements mandated by regulatory agencies and appropriate professional organizations, such as the College of American Pathologists (CAP). ^(Core)
- II.D.4.a) Tests should include measurement of blood chemistries, blood gases and pH, culture and sensitivity, toxicology, and analysis of plasma drug concentrations. ^(Detail)

II.D.5. There must be facilities for routine and special radiologic imaging procedures, including interventional radiology and bedside ultrasound. (Core)

II.D.5.a) Access to all radiologic studies and their interpretation must be available within the ICU environment utilizing electronic data systems such as Picture Archiving and Communication Systems (PACS). (Core)

II.D.5.b) The ICU must have ultrasound equipment available to perform diagnostic assessment for procedures such as thoracentesis, paracentesis, vascular access (i.e., peripherally-inserted central catheters, central catheter placement, and arterial cannulation), and comprehensive ultrasound evaluation, including echocardiography and focused assessment with sonography examinations (i.e., fast scans). (Detail)

II.E. Medical Information Access

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

III. Fellow Appointments

III.A. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC-accredited residency program located in Canada. (Core)

Prior to appointment to the program, fellows must have completed an ACGME- or RCPSC-accredited residency in anesthesiology or emergency medicine; or at least three clinical years in an ACGME- or RCPSC-accredited residency in neurological surgery, obstetrics and gynecology, orthopaedic surgery, otolaryngology, surgery, thoracic surgery, vascular surgery, or urology. (Core)

III.A.1. **Fellowship programs must receive verification of each entering fellow's level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program.** (Core)

III.A.2. Fellow Eligibility Exception

A Review Committee may grant the following exception to the fellowship eligibility requirements:

An ACGME-accredited fellowship program may accept an exceptionally qualified applicant, who does not satisfy the**

eligibility requirements listed in Sections III.A. and III.A.1., but who does meet all of the following additional qualifications and conditions: ^(Core)

- III.A.2.a) **Assessment by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and** ^(Core)
- III.A.2.b) **Review and approval of the applicant's exceptional qualifications by the GMEC or a subcommittee of the GMEC; and** ^(Core)
- III.A.2.c) **Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and;** ^(Core)
- III.A.2.d) **For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and,** ^(Core)
- III.A.2.e) **Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant's Milestones evaluation conducted at the conclusion of the residency program.** ^(Core)
- III.A.2.e).(1) **If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training.** ^(Core)

**** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.**

III.A.3. The Review Committee for Anesthesiology does allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A.
(Core)

III.B. Number of Fellows

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

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

III.B.1.a) The presence of other learners or staff members in the program must not interfere with the fellows' education. (Detail)

IV. Educational Program

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

IV.A.1. Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills and competencies to fellows and faculty at least annually, in either written or electronic form. (Core)

IV.A.1.a) All educational components of the program should be related to the program goals. (Core)

IV.A.2. ACGME Competencies

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

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

IV.A.2.a).(1) Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows: (Outcome)

IV.A.2.a).(1).(a) must demonstrate competence in providing clinical care and consultation, under the direction and supervision of faculty members, by evaluating a patient's medical condition, determining the need for critical care services, and, as appropriate formulating a plan of care, including: (Outcome)

IV.A.2.a).(1).(a).(i) incorporation of ethical aspects of critical care medicine into practice; (Outcome)

IV.A.2.a).(1).(a).(ii) diagnosis and management of

- cardiovascular dysfunction; (Outcome)
- IV.A.2.a).(1).(a).(iii) diagnosis and management of pulmonary dysfunction; (Outcome)
- IV.A.2.a).(1).(a).(iv) diagnosis and management of sepsis and septic shock; (Outcome)
- IV.A.2.a).(1).(a).(v) diagnosis and management of renal dysfunction, to include techniques for renal replacement therapies; (Outcome)
- IV.A.2.a).(1).(a).(vi) diagnosis and management of hematologic disorders, to include coagulopathies; (Outcome)
- IV.A.2.a).(1).(a).(vii) diagnosis and treatment of hepatic dysfunction; (Outcome)
- IV.A.2.a).(1).(a).(viii) evaluation and management of central and peripheral nervous system dysfunction; (Outcome)
- IV.A.2.a).(1).(a).(ix) management of life threatening medical illness, to include oncologic, dermatologic, and endocrinologic illnesses; (Outcome)
- IV.A.2.a).(1).(a).(x) indications for and interpretation of laboratory results; (Outcome)
- IV.A.2.a).(1).(a).(xi) psychiatric implications of critical illness; (Outcome)
- IV.A.2.a).(1).(a).(xii) palliative and end-of-life care; (Outcome)
- IV.A.2.a).(1).(a).(xiii) routine incorporation of standards of care and established guidelines or procedures for patient safety and error reduction; and, (Outcome)
- IV.A.2.a).(1).(a).(xiv) demonstration of patient management and psychomotor (procedural) skills required for the practice of the subspecialty. (Outcome)
- IV.A.2.a).(1).(b) must demonstrate competence in coordinating care across medical specialties, as appropriate, to communicate patient status, plans of care, and long-term needs of the patient to other health care providers, and to collaborate in the management of the critically-ill patient. (Outcome)

IV.A.2.a).(2)

Fellows must be able to competently perform all

medical, diagnostic, and surgical procedures considered essential for the area of practice. Fellows:
(Outcome)

- IV.A.2.a).(2).(a) must demonstrate proficiency in procedural skills and sound clinical judgment in the care of patients with complex medical and surgical conditions, including: (Outcome)
- IV.A.2.a).(2).(a).(i) airway maintenance and management, to include fiberoptic approaches to the airway for both diagnostic and therapeutic purposes; (Outcome)
- IV.A.2.a).(2).(a).(ii) indications for and placement of percutaneous tracheostomies; (Outcome)
- IV.A.2.a).(2).(a).(iii) invasive and non-invasive ventilatory support; (Outcome)
- IV.A.2.a).(2).(a).(iv) techniques for and therapeutic treatment of conditions requiring thoracentesis and/or tube thoracotomy when indicated; (Outcome)
- IV.A.2.a).(2).(a).(v) diagnosis and pharmacologic and mechanical support of circulation, myocardial function, and shock; (Outcome)
- IV.A.2.a).(2).(a).(vi) cardiopulmonary resuscitation (CPR); (Outcome)
- IV.A.2.a).(2).(a).(vi).(a) Fellows must be certified in advanced cardiovascular life support (ACLS) throughout their anesthesiology critical care medicine education. (Outcome)
- IV.A.2.a).(2).(a).(vii) placement and management of arterial, central venous, and pulmonary arterial catheters; (Outcome)
- IV.A.2.a).(2).(a).(viii) emergent and therapeutic placement of pacemakers; (Outcome)
- IV.A.2.a).(2).(a).(ix) fluid resuscitation and management of massive blood loss; (Outcome)
- IV.A.2.a).(2).(a).(x) prescribing enteral and total parenteral nutrition; (Outcome)
- IV.A.2.a).(2).(a).(xi) ultrasonography for transthoracic (TTE) and

transesophageal (TEE) echocardiography, facilitation of invasive catheter placement, and diagnostic studies and therapeutic interventions relevant to the critically-ill patient; and, (Outcome)

IV.A.2.a).(2).(a).(xii)

pain management, sedation, and anxiolysis for the critically-ill patient. (Outcome)

IV.A.2.b)

Medical Knowledge

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

IV.A.2.b).(1)

must demonstrate knowledge of those areas appropriate for a subspecialist in anesthesiology critical care medicine, including: (Outcome)

IV.A.2.b).(1).(a)

resuscitation; (Outcome)

IV.A.2.b).(1).(b)

cardiovascular physiology, pathology, pathophysiology, and therapy; (Outcome)

IV.A.2.b).(1).(c)

respiratory physiology, pathology, pathophysiology, and therapy; (Outcome)

IV.A.2.b).(1).(d)

renal physiology, pathology, pathophysiology, and therapy; (Outcome)

IV.A.2.b).(1).(e)

central and peripheral nervous system physiology, pathology, pathophysiology, and therapy; (Outcome)

IV.A.2.b).(1).(f)

pain management, sedation, and anxiolysis for critically-ill patients; (Outcome)

IV.A.2.b).(1).(g)

recognition and management of altered states of consciousness, to include delirium; (Outcome)

IV.A.2.b).(1).(h)

metabolic and endocrine effects of critical illness; (Outcome)

IV.A.2.b).(1).(i)

infectious disease physiology, pathology, pathophysiology, and therapy; (Outcome)

IV.A.2.b).(1).(j)

primary hematologic disorders and hematologic disorders secondary to critical illness; (Outcome)

IV.A.2.b).(1).(k)

transfusion therapy; (Outcome)

IV.A.2.b).(1).(l)	gastrointestinal, genitourinary, obstetric, and gynecologic disorders; (Outcome)
IV.A.2.b).(1).(m)	trauma, to include burn management; (Outcome)
IV.A.2.b).(1).(n)	monitoring equipment for the care of critically-ill patients and basic concepts of bioengineering, to include the principles of ultrasound, Doppler, and other medical imaging techniques relevant to critical care medicine; (Outcome)
IV.A.2.b).(1).(o)	life-threatening pediatric conditions; (Outcome)
IV.A.2.b).(1).(p)	palliative and end-of-life care; (Outcome)
IV.A.2.b).(1).(q)	pharmacokinetics and dynamics, to include drug metabolism and excretion in critical illness; (Outcome)
IV.A.2.b).(1).(r)	coordination of transport and triage of critically-ill patients; (Outcome)
IV.A.2.b).(1).(s)	coordination of care for the patient with multisystem failure requiring evaluation and management by a diverse group of providers; (Outcome)
IV.A.2.b).(1).(t)	administrative and management principles, to include triage, resource utilization, and rationing of limited resources; (Outcome)
IV.A.2.b).(1).(u)	understanding about the value and use of critical care electronic health records and integration with other medical record systems; (Outcome)
IV.A.2.b).(1).(v)	medical informatics and biostatistics relevant to critical care medicine; (Outcome)
IV.A.2.b).(1).(w)	effective interpersonal and communication skills with patients, family members, and other health care providers; (Outcome)
IV.A.2.b).(1).(x)	cost-effective care; (Outcome)
IV.A.2.b).(1).(y)	ethics and legal issues related to the care of critically-ill patients, to include surrogate decision-making, advance directives, and management of disagreements between providers and patients regarding resource use; (Outcome)
IV.A.2.b).(1).(z)	psychiatric implications of critical illness; and, (Outcome)

- IV.A.2.b).(1).(aa) ICU management, to include: (Outcome)
- IV.A.2.b).(1).(aa).(i) development and implementation of policies and procedures related to ICU administration (admission, discharge, etc.); (Outcome)
- IV.A.2.b).(1).(aa).(ii) development and implementation of evidence-based approaches to clinical care and clinical guidelines to optimize patient outcomes and minimize needless variations in care delivery; (Outcome)
- IV.A.2.b).(1).(aa).(iii) regulatory requirements that apply to critical care units, including those of The Joint Commission and other regulatory agencies; (Outcome)
- IV.A.2.b).(1).(aa).(iv) financial aspects of ICU management and the implications for allocation of institutional resources and overall costs of care; (Outcome)
- IV.A.2.b).(1).(aa).(v) resource utilization, including personnel management and staffing patterns; (Outcome)
- IV.A.2.b).(1).(aa).(vi) patient triage and coordination of care with other hospital units (acute care, transitional care, post-anesthesia care unit, etc.); (Outcome)
- IV.A.2.b).(1).(aa).(vii) quality of care, patient safety initiatives, and patient and family satisfaction; and, (Outcome)
- IV.A.2.b).(1).(aa).(viii) risk stratification and outcome measurement, such as Acute Physiology and Chronic Health Evaluation (APACHE) and other scoring systems. (Outcome)

IV.A.2.c)

Practice-based Learning and Improvement

Fellows are expected to develop skills and habits to be able to meet the following goals:

- IV.A.2.c).(1) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; (Outcome)**
- IV.A.2.c).(2) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; and, (Outcome)**

IV.A.2.c).(3) demonstrate acquisition of the skills and habits of self-assessment and reflection. (Outcome)

IV.A.2.d) 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. (Outcome)

IV.A.2.d).(1) Fellows must demonstrate competence in:
effective communication skills with patients and their families or surrogates, including acquisition of informed consent, communication about prognosis and likelihood of recovery, and disclosure of complications and errors and their management; (Outcome)

IV.A.2.d).(2) teaching, including the preparation and presentation of educational material for patients, residents, medical students, and other health care professionals in the subspecialty area; (Outcome)

IV.A.2.d).(3) communication, coordination, and collaboration with other providers, including other physicians, nurses and advance practice nurses, respiratory therapists, and case managers; and, (Outcome)

IV.A.2.d).(4) supervision of residents and medical students throughout the duration of the fellowship. (Outcome)

IV.A.2.e) Professionalism

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Fellows must demonstrate competence in:

IV.A.2.e).(1) compassion, integrity, and respect for others; (Outcome)

IV.A.2.e).(2) responsiveness to patient needs; (Outcome)

IV.A.2.e).(3) respect for patient privacy and autonomy; (Outcome)

IV.A.2.e).(4) accountability to patients, society, and the profession; (Outcome)

IV.A.2.e).(5) sensitivity and responsiveness to a diverse patient population, including diversity in gender, age, culture, race, religion, disabilities, and sexual orientation; and, (Outcome)

IV.A.2.e).(6) compliance with institutional, departmental, and program policies. ^(Outcome)

IV.A.2.f) Systems-based Practice

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.
^(Outcome)

Fellows must demonstrate competence in:

IV.A.2.f).(1) working in interprofessional teams to enhance patient safety and improve patient care quality; ^(Outcome)

IV.A.2.f).(2) identifying system errors and potential errors (near misses), and assisting in the implementation of potential system solutions; and, ^(Outcome)

IV.A.2.f).(3) administrative and management skills related to delivery of critical care services, resource utilization, and triage of critically-ill patients. ^(Outcome)

IV.A.3. Curriculum Organization and Fellow Experiences

IV.A.3.a) At least nine of the 12 months of education must be spent in the care of critically-ill patients in ICUs or transitional care units. ^(Core)

IV.A.3.a).(1) The remainder of the time must be spent in elective clinical activities, research, or scholarly activity relevant to critical care. ^(Core)

IV.A.3.a).(2) Rotations outside the institution in which the program is based, including ICU rotations and electives, should not exceed four months. ^(Detail)

IV.A.3.b) The program must provide educational programs and direct experience in administrative and management aspects of critical care medicine, as well as education about research methodology and interpretation of findings in published literature. ^(Core)

IV.A.3.c) Educational sessions and subspecialty conferences must be conducted on a regular basis. ^(Core)

IV.A.3.c).(1) Conferences should include formal seminars, clinical and basic science instruction, and review of all morbidity and mortality relevant to the subspecialty services. ^(Detail)

IV.A.3.c).(2) Fellows must be involved in the planning, development, and execution of subspecialty educational sessions. ^(Detail)

IV.A.3.d) Fellows must participate in conferences and educational sessions of both the core anesthesiology residency and the fellowship program. ^(Core)

IV.A.3.d).(1) Fellows should attend all multidisciplinary conferences, with particular attention given to those conferences relevant to anesthesiology critical care medicine. ^(Detail)

IV.A.3.d).(2) Documentation of fellow participation in these conferences must be maintained. ^(Detail)

IV.B. Fellows' Scholarly Activities

IV.B.1. The program must provide instruction in the fundamentals of research design and conduct, and the interpretation and presentation of data. ^(Detail)

IV.B.2. During the program, fellows must participate in at least one clinical or other research project related to critical care medicine. ^(Core)

IV.B.2.a) Results of each project must be disseminated through publication or presentation at local, regional, national, or international meetings. ^(Detail)

V. Evaluation

V.A. Fellow Evaluation

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

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

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

V.A.1.a).(1).(a) These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows in patient care and other health care settings. ^(Core)

V.A.1.a).(1).(b) Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee. ^(Core)

V.A.1.b) There must be a written description of the responsibilities of

- V.A.2.b).(4) review fellow procedure logs quarterly. ^(Detail)
- V.A.2.c) **The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.** ^(Detail)
- V.A.3. **Summative Evaluation**
- V.A.3.a) **The specialty-specific Milestones must be used as one of the tools to ensure fellows are able to practice core professional activities without supervision upon completion of the program.** ^(Core)
- V.A.3.b) **The program director must provide a summative evaluation for each fellow upon completion of the program.** ^(Core)
- This evaluation must:**
- V.A.3.b).(1) **become part of the fellow’s permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy;** ^(Detail)
- V.A.3.b).(2) **document the fellow’s performance during their education; and,** ^(Detail)
- V.A.3.b).(3) **verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.** ^(Detail)
- V.B. **Faculty Evaluation**
- V.B.1. **At least annually, the program must evaluate faculty performance as it relates to the educational program.** ^(Core)
- V.B.2. **These evaluations should include a review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.** ^(Detail)
- V.B.3. **Written, confidential evaluations of critical care medicine faculty member performance by each fellow must take place at least once a year.** ^(Detail)
- V.C. **Program Evaluation and Improvement**
- V.C.1. **The program director must appoint the Program Evaluation Committee (PEC).** ^(Core)
- V.C.1.a) **The Program Evaluation Committee:**
- V.C.1.a).(1) **must be composed of at least two program faculty**

- members and should include at least one fellow; ^(Core)
- V.C.1.a).(2) must have a written description of its responsibilities; and, ^(Core)
- V.C.1.a).(3) should participate actively in:
- V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; ^(Detail)
- V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; ^(Detail)
- V.C.1.a).(3).(c) addressing areas of non-compliance with ACGME standards; and, ^(Detail)
- V.C.1.a).(3).(d) reviewing the program annually using evaluations of faculty, fellows, and others, as specified below. ^(Detail)
- V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation. ^(Core)
- The program must monitor and track each of the following areas:
- V.C.2.a) fellow performance; ^(Core)
- V.C.2.b) faculty development; ^(Core)
- V.C.2.c) progress on the previous year's action plan(s); and, ^(Core)
- V.C.2.d) graduate performance. ^(Core)
- V.C.2.d).(1) At least 70 percent of a program's graduates from the most recent five-year period who take the American Board of Anesthesiology Critical Care Medicine certifying examination for the first time must pass. ^(Outcome)
- V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. ^(Core)
- V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. ^(Detail)

VI. The Learning and Working Environment

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

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

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

VI.A.1. Patient Safety and Quality Improvement

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

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

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

VI.A.1.a) Patient Safety

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

patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. ^(Core)

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

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

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

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

VI.A.1.b) Quality Improvement

VI.A.1.b).(1) Education in Quality Improvement

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

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

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

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

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

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

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

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

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

VI.A.2. Supervision and Accountability

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

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

VI.A.2.a).(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. ^(Core)

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

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

VI.A.2.b) *Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback.*

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

VI.A.2.c) Levels of Supervision

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

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

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

VI.A.2.c).(2).(a) with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. ^(Core)

VI.A.2.c).(2).(b) with Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. ^(Core)

VI.A.2.c).(3) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. ^(Core)

VI.A.2.d) The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. ^(Core)

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

VI.A.2.d).(2) Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow. ^(Core)

VI.A.2.d).(3) Fellows should serve in a supervisory role to residents or junior fellows in recognition of their progress

toward independence, based on the needs of each patient and the skills of the individual resident or fellow. ^(Detail)

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

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

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

VI.B. Professionalism

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

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

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

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

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

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

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)

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

- 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)
- VI.B.5. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Outcome)
- VI.B.6. Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents/fellows, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)
- VI.C. Well-Being
- In the current health care environment, fellows and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of fellowship training. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of fellow competence.*
- VI.C.1. This responsibility 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)
- VI.C.1.d) policies and programs that encourage optimal fellow and faculty member well-being; and, ^(Core)
- 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)
- VI.C.1.e) attention to fellow and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and fellows in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Fellows and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: ^(Core)
- VI.C.1.e).(1) encourage fellows and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; ^(Core)
- VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, ^(Core)
- VI.C.1.e).(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. ^(Core)
- VI.C.2. There are circumstances in which fellows may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a fellow may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the fellow who is unable to provide the clinical work. ^(Core)

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)
- VI.D.2.** Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in VI.C.2, in the event that a fellow may be unable to perform their patient care responsibilities due to excessive fatigue. ^(Core)
- VI.D.3.** The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for fellows who may be too fatigued to safely return home. ^(Core)
- VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care**
- VI.E.1. Clinical Responsibilities**
- The clinical responsibilities for each fellow must be based on PGY level, patient safety, fellow ability, severity and complexity of patient illness/condition, and available support services. ^(Core)
- VI.E.1.a)** An optimal clinical workload allows fellows to complete the required case numbers, gain expertise in the required clinical components, and/or develop required competencies in patient care with a focus on learning over meeting service obligations. ^(Detail)
- VI.E.2. Teamwork**
- Fellows must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. ^(Core)
- VI.E.2.a)** Interprofessional teams may include non-physician health care professionals, e.g., medical assistants, specialized nurses, and technicians. ^(Detail)
- VI.E.3. Transitions of Care**
- VI.E.3.a)** Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. ^(Core)

- VI.E.3.b) **Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.** ^(Core)
- VI.E.3.c) **Programs must ensure that fellows are competent in communicating with team members in the hand-over process.** ^(Outcome)
- VI.E.3.d) **Programs and clinical sites must maintain and communicate schedules of attending physicians and fellows currently responsible for care.** ^(Core)
- VI.E.3.e) **Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a fellow may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.** ^(Core)

VI.F. Clinical Experience and Education

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

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

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. ^(Core)
- VI.F.2. **Mandatory Time Free of Clinical Work and Education**
 - VI.F.2.a) **The program must design an effective program structure that is configured to provide fellows with educational opportunities, as well as reasonable opportunities for rest and personal well-being.** ^(Core)
 - VI.F.2.b) **Fellows should have eight hours off between scheduled clinical work and education periods.** ^(Detail)
 - VI.F.2.b).(1) **There may be circumstances when fellows choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.** ^(Detail)
 - VI.F.2.c) **Fellows must have at least 14 hours free of clinical work and**

education after 24 hours of in-house call. ^(Core)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Policies and Procedures. (Core)

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

VI.F.5. Moonlighting

VI.F.5.a) Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program, and must not interfere with the fellow's fitness for work nor compromise patient safety. (Core)

VI.F.5.b) Time spent by fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)

VI.F.6. In-House Night Float

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core)

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)

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

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance

with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

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

Osteopathic Recognition

For programs seeking Osteopathic Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable.

(http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf)