

# ACGME Program Requirements for Graduate Medical Education in Pediatric Anesthesiology

One-year Common Program Requirements are in BOLD

Effective: January 1, 2004

## 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. Definition and Scope of the Specialty

Pediatric anesthesiology is the subspecialty of anesthesiology devoted to the pre-operative, intra-operative, and post-operative anesthetic care of pediatric patients.

Int.C. Duration and Scope of Education

Subspecialty training in pediatric anesthesiology shall be 12 months in duration, beginning after satisfactory completion of the residency program in anesthesiology. Subspecialty training in pediatric anesthesiology is in addition to the minimum requirements described in the program requirements for the core program in anesthesiology.

The clinical training in pediatric anesthesiology must be spent caring for pediatric patients in the operating rooms, other anesthetizing locations, and in intensive care units. The training will include experience in providing anesthesia both for

inpatient and outpatient surgical procedures and for non-operative procedures outside the operating rooms, as well as pre-anesthesia preparation and post-anesthesia care, pain management, and advanced life support for neonates, infants, children, and adolescents.

Int.D. Goals and Objectives

The subspecialty program in pediatric anesthesiology must be structured to ensure optimal patient care while providing fellows the opportunity to develop skills in clinical care and judgment, teaching, administration, and research. The subspecialist in pediatric anesthesiology should be proficient not only in providing anesthesia care for neonates, infants, children, and adolescents undergoing a wide variety of surgical, diagnostic, and therapeutic procedures, but also in pain management, critical peri-operative care, and advanced life support. To meet these goals, the program should provide exposure to the wide variety of clinical problems in pediatric patients, as outlined in IV.A.4-IV.A.6 that are necessary for the development of these clinical skills.

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.**

**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.**

I.A.1. A pediatric anesthesiology program should function whenever feasible in direct association and/or affiliation with an Accreditation Council for Graduate Medical Education (ACGME)-accredited core anesthesiology program. However, a pediatric anesthesiology program may be conducted in either a general hospital or a children's hospital. If the program is conducted in a general hospital, there must be within the same institution a fully accredited core anesthesiology program with which the pediatric anesthesiology program is associated. When the core program and the subspecialty program are conducted within the same institution, the division of responsibilities between residents in the core program and those fellows in the subspecialty program must be clearly delineated.

If the pediatric anesthesiology program is conducted in a children's hospital, there are two sponsorship options:

I.A.1.a) the program may be under the sponsorship of another institution that conducts a fully accredited core anesthesiology residency program, in which case there must be an affiliation agreement between the two institutions; or,

I.A.1.b) the program may be under the direct sponsorship of the children's hospital, in which case the children's hospital must be the sponsoring institution for an ACGME-accredited core pediatric residency and at least one pediatric subspecialty program that is under a primary specialty other than pediatrics. There must also be a GMEC in the children's hospital that assumes the responsibility of a sponsoring institution as stipulated in the Institutional Requirements.

## **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.**

**The PLA should:**

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

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

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

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

**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).**

## **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. After approval, the program director must submit this change to the ACGME via the ADS.**

**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;**

- II.A.2.b) current certification in the specialty by the American Board of Anesthesiology, or specialty qualifications that are acceptable to the Review Committee; and,**
- II.A.2.c) current medical licensure and appropriate medical staff appointment.**
  - II.A.2.c).(1) The program director also must be licensed to practice medicine in the state where the institution that sponsors the program is located (certain federal programs are exempted).
  - II.A.2.c).(2) The program director must have completed a pediatric anesthesiology training program or have equivalent educational and clinical qualifications in providing anesthesia care for pediatric patients.
- 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. The program director must:**
  - II.A.3.a) prepare and submit all information required and requested by the ACGME;**
  - 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;**
  - II.A.3.c) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:**
    - II.A.3.c).(1) all applications for ACGME accreditation of new programs;
    - II.A.3.c).(2) changes in fellow complement;
    - II.A.3.c).(3) major changes in program structure or length of training;
    - II.A.3.c).(4) progress reports requested by the Review Committee;
    - II.A.3.c).(5) responses to all proposed adverse actions;
    - II.A.3.c).(6) requests for increases or any change to fellow duty hours;
    - II.A.3.c).(7) voluntary withdrawals of ACGME-accredited programs;

- II.A.3.c).(8) requests for appeal of an adverse action; and,
- II.A.3.c).(9) appeal presentations to a Board of Appeal or the ACGME.
- II.A.3.d) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:
  - II.A.3.d).(1) program citations, and/or
  - II.A.3.d).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.
- II.A.3.e) prepare, review periodically, and, if necessary, revise a written outline of the educational goals of the program with respect to the knowledge, skills, and other attributes of fellows at each level of training and for each major rotation or other program assignment;
- II.A.3.e).(1) This statement must be distributed to fellows and members of the teaching staff, and should be readily available for review.
- II.A.3.f) select fellows for appointment to the program in accordance with institutional and departmental policies and procedures;
- II.A.3.g) select and supervise the teaching staff and other program personnel;
- II.A.3.h) supervise fellows through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines must be communicated to all fellows and faculty;
  - II.A.3.h).(1) Fellows must be provided with prompt, reliable systems for communication and interaction with supervisory physicians.
- II.A.3.i) implement fair procedures, as established by the sponsoring institution, regarding academic discipline and resident complaints or grievances; and,
- II.A.3.j) prepare an accurate statistical and narrative description of the program, as requested by the Review Committee.
- II.A.4. The program director must devote sufficient time to provide adequate leadership to the program and supervision for the fellows. The clinical director of the pediatric anesthesiology service may be someone other than the program director.

**II.B. Faculty**

- II.B.1. There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.**
- II.B.1.a) Although the number of faculty members involved in teaching fellows in will vary, it is recommended that at least three faculty members be involved, and that these be equal to or greater than two FTEs, including the program director. A ratio of no less than one FTE faculty member to one subspecialty fellow shall be maintained. The Review Committee understands that full-time means that the faculty member devotes essentially all professional time to the program.
- 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.**
- II.B.3. The physician faculty must have current certification in the subspecialty by the American Board of Anesthesiology, or possess qualifications acceptable to the Review Committee.**
- II.B.4. The physician faculty must possess current medical licensure and appropriate medical staff appointment.**
- II.B.5. There must be evidence of active participation by qualified physicians with training and/or expertise in pediatric anesthesiology beyond the requirement for completion of a core anesthesiology residency. The faculty must possess expertise in the care of pediatric patients and must have a continuous and meaningful role in the subspecialty training program.
- II.B.6. The program should include teaching in multidisciplinary conferences by faculty in pediatric and neonatal intensive care, pediatric medicine, and pediatric surgery.
- II.B.7. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. *Scholarship* is defined as the following:
- II.B.7.a) the scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;
- II.B.7.b) the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks;
- II.B.7.c) the scholarship of *application*, as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings.

II.B.8. Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for fellows involved in research such as research design and statistical analysis); and the provision of support for fellows' participation, as appropriate, in scholarly activities.

II.B.9. The program director and faculty members responsible for teaching fellows must maintain an active role in scholarly pursuits pertaining to pediatric anesthesiology, as evidenced by participation in continuing medical education as well as by involvement in research as it pertains to the care of pediatric patients.

### 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.**

### 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.**

#### II.D.1. Institutional Policy

There should be an institutional policy governing the educational resources committed to pediatric anesthesiology programs.

#### II.D.2. The following resources and facilities are necessary to the program:

II.D.2.a) intensive care units for both newborns and older children;

II.D.2.b) an emergency department in which children of all ages can be effectively managed 24 hours a day;

II.D.2.c) operating rooms adequately designed and equipped for the management of pediatric patients;

II.D.2.c).(1) A post-anesthesia care area adequately designed and equipped for the management of pediatric patients must be located near the operating room suite.

II.D.2.d) pediatric surgical patients in sufficient volume and variety to provide a broad educational experience for the program;

II.D.2.d).(1) Surgeons with special pediatric training and/or experience in general surgery, cardiovascular surgery, neurological

surgery, otolaryngology, ophthalmology, orthopaedic surgery, plastic surgery, and urology must be available.

- II.D.2.e) monitoring and advanced life-support equipment representative of current levels of technology;
  - II.D.2.f) allied health staff and other support personnel; and,
  - II.D.2.g) facilities that are readily available at all times to provide prompt laboratory measurements pertinent to the care of pediatric patients, including but not limited to measurement of blood chemistries, blood gases and pH, oxygen saturation, hematocrit/hemoglobin, and clotting function.
- II.D.3. If adequate clinical experiences are not provided in the primary institution, arrangements should be made to ensure that adequate clinical experiences are obtained.
- II.D.3.a) The total time in rotations outside the primary institution for the purpose of supplemental experience should not exceed three months and should be approved by the Review Committee.

## **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.**

## **III. Fellow Appointments**

### **III.A. Eligibility Criteria**

**Each fellow must successfully complete an ACGME-accredited specialty program and/or meet other eligibility criteria as specified by the Review Committee. The program must document that each fellow has met the eligibility criteria.**

### **III.B. Number of Fellows**

**The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of fellows appointed to the program.**

## **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 annually, in either written**

or electronic form. These skills and competencies should be reviewed by the fellow at the start of each rotation;

**IV.A.2. ACGME Competencies**

The program must integrate the following ACGME competencies into the curriculum:

**IV.A.2.a) Patient Care**

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.

**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.

**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; and,**

**IV.A.2.c).(2) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.**

**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.

**IV.A.2.e) Professionalism**

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

**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.**

IV.A.3. Goals and Objectives

The program director and teaching staff must prepare and comply with written goals for the program. All educational components of the program should be related to the program goals. The program design must be approved by the Review Committee as part of the regular review process. A written statement of the educational objectives must be given to each fellow.

IV.A.4. Clinical Components

Fellows should gain expertise in the following areas of clinical care of neonates, infants, children, and adolescents:

- IV.A.4.a) preoperative assessment of children scheduled for surgery;
- IV.A.4.b) cardiopulmonary resuscitation and advanced life support;
- IV.A.4.c) management of normal and abnormal airways;
- IV.A.4.d) mechanical ventilation;
- IV.A.4.e) temperature regulation;
- IV.A.4.f) placement of venous and arterial catheters;
- IV.A.4.g) pharmacologic support of the circulation;
- IV.A.4.h) management of both normal peri-operative fluid therapy and massive fluid and/or blood loss;
- IV.A.4.i) interpretation of laboratory results;
- IV.A.4.j) management of children requiring general anesthesia for elective and emergent surgery for a wide variety of surgical conditions including neonatal surgical emergencies, cardiopulmonary bypass, and congenital disorders;
- IV.A.4.k) techniques for administering regional anesthesia for inpatient and ambulatory surgery in children;
- IV.A.4.l) sedation or anesthesia for children outside the operating rooms, including those undergoing radiologic studies;
- IV.A.4.m) recognition, prevention, and treatment of pain in medical and surgical patients;
- IV.A.4.n) consultation for medical and surgical patients;

- IV.A.4.o) recognition and treatment of peri-operative vital organ dysfunction, including in the post-anesthesia care unit;
- IV.A.4.p) diagnosis and peri-operative management of congenital and acquired disorders;
- IV.A.4.q) participation in the care of critically-ill infants and children in a neonatal and/or pediatric intensive care unit;
- IV.A.4.r) transport of critically-ill patients between hospitals and/or within the hospital; and,
- IV.A.4.s) psychological support of patients and their families.
- IV.A.5. In preparation for roles as consultants to other specialists, fellows should have the opportunity to provide consultation under the direction of faculty members responsible for teaching in the program. This should include assessment of the appropriateness of a patient's preparation for surgery and recognition of when an institution's personnel, equipment, and/or facilities are not appropriate for management of the patient.
- IV.A.6. Didactic Components  
  
The didactic curriculum, provided through lectures and reading, should include the following areas, with emphasis on developmental and maturational aspects as they pertain to anesthesia and life support for pediatric patients:
  - IV.A.6.a) cardiopulmonary resuscitation;
  - IV.A.6.b) pharmacokinetics and pharmacodynamics and mechanisms of drug delivery;
  - IV.A.6.c) cardiovascular, respiratory, renal, hepatic, and central nervous system physiology, pathophysiology, and therapy;
  - IV.A.6.d) metabolic and endocrine effects of surgery and critical illness;
  - IV.A.6.e) infectious disease pathophysiology and therapy;
  - IV.A.6.f) coagulation abnormalities and therapy;
  - IV.A.6.g) normal and abnormal physical and psychological development;
  - IV.A.6.h) trauma, including burn, management;
  - IV.A.6.i) congenital anomalies and developmental delay;
  - IV.A.6.j) medical and surgical problems common in children;

- IV.A.6.k) use and toxicity of local and general anesthetic agents;
- IV.A.6.l) airway problems common in children;
- IV.A.6.m) pain management in pediatric patients of all ages;
- IV.A.6.n) ethical and legal aspects of care;
- IV.A.6.o) transport of critically-ill patients; and,
- IV.A.6.p) organ transplantation in children.
- IV.A.7. All fellows should be certified as providers of advanced life support for children.
- IV.A.8. Subspecialty conferences, including morbidity and mortality conferences, journal reviews, and research seminars, should be regularly attended. Active participation by each fellow in the planning and production of these conferences is essential. However, faculty members should be the conference leaders in the majority of the sessions. Attendance by fellows at multidisciplinary conferences, especially those relevant to pediatric anesthesiology, is encouraged.

#### **IV.B. Fellows' Scholarly Activities**

The program should provide the opportunity for active resident participation in research projects pertinent to pediatric anesthesia. Fellows should be instructed in the conduct of scholarly activities and the evaluation of investigative methods and interpretation of data, including statistics; they should have the opportunity to develop competence in critical assessment of new therapies and of the medical literature.

### **V. Evaluation**

#### **V.A. Fellow Evaluation**

##### **V.A.1. Formative Evaluation**

##### **V.A.1.a) The faculty must evaluate fellow performance in a timely manner.**

V.A.1.a).(1) Faculty members responsible for teaching fellows must provide critical evaluations of each fellow's progress and competence to the program director at the end of six months and 12 months of training.

V.A.1.a).(1).(a) These evaluations should include attitude, interpersonal relationships, fund of knowledge, manual skills, patient management, decision-making skills, and critical analysis of clinical situations.

V.A.1.a).(1).(b) The program director or designee must inform each fellow of the results of evaluations at least every six months during training, advise each fellow on areas needing improvement, and document the communication.

V.A.1.a).(1).(c) Fellows must obtain overall satisfactory evaluations at completion of 12 months of training to receive credit for training.

**V.A.1.b) The program must:**

**V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**

**V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and,**

**V.A.1.b).(3) provide each fellow with documented semiannual evaluation of performance with feedback.**

**V.A.1.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.**

**V.A.2. Summative Evaluation**

**The program director must provide a summative evaluation for each fellow upon completion of the program. This evaluation must become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy. This evaluation must:**

**V.A.2.a) document the fellow's performance during their education, and**

**V.A.2.b) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.**

**V.B. Faculty Evaluation**

**V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.**

**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.**

V.B.3. There must be a regular opportunity for fellows to provide written, confidential evaluations of faculty members and the program.

**V.C. Program Evaluation and Improvement**

**V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:**

**V.C.1.a) fellow performance, and**

**V.C.1.b) faculty development**

**V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.**

V.C.3. Periodic evaluation of patient care (quality assurance) is mandatory. Fellows should be involved in continuous quality improvement, utilization review, and risk management.

V.C.4. Periodic evaluation of subspecialty training objectives is encouraged.

**VI. Fellow Duty Hours in the Learning and Working Environment**

**VI.A. Professionalism, Personal Responsibility, and Patient Safety**

**VI.A.1. Programs and sponsoring institutions must educate fellows and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.**

**VI.A.2. The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational environment.**

**VI.A.3. The program director must ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.**

**VI.A.4. The learning objectives of the program must:**

**VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,**

**VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill non-physician service obligations.**

- VI.A.5.** The program director and sponsoring institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:
- VI.A.5.a)** assurance of the safety and welfare of patients entrusted to their care;
  - VI.A.5.b)** provision of patient- and family-centered care;
  - VI.A.5.c)** assurance of their fitness for duty;
  - VI.A.5.d)** management of their time before, during, and after clinical assignments;
  - VI.A.5.e)** recognition of impairment, including illness and fatigue, in themselves and in their peers;
  - VI.A.5.f)** attention to lifelong learning;
  - VI.A.5.g)** the monitoring of their patient care performance improvement indicators; and,
  - VI.A.5.h)** honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.
- VI.A.6.** All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize 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.
- VI.B. Transitions of Care**
- VI.B.1.** Programs must design clinical assignments to minimize the number of transitions in patient care.
  - VI.B.2.** Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
  - VI.B.3.** Programs must ensure that fellows are competent in communicating with team members in the hand-over process.
  - VI.B.4.** The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient's care.
- VI.C. Alertness Management/Fatigue Mitigation**

- VI.C.1. The program must:**
- VI.C.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;**
  - VI.C.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,**
  - VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.**
- VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties.**
- VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home.**
- VI.D. Supervision of Fellows**
- VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.**
    - VI.D.1.a) This information should be available to fellows, faculty members, and patients.**
    - VI.D.1.b) Fellows and faculty members should inform patients of their respective roles in each patient's care.**
  - VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients.**

**Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. 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 in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback as to the appropriateness of that care.**
  - VI.D.3. Levels of Supervision**

**To ensure oversight of fellow supervision and graded authority and**

responsibility, the program must use the following classification of supervision:

- VI.D.3.a) **Direct Supervision – the supervising physician is physically present with the fellow and patient.**
- VI.D.3.b) **Indirect Supervision:**
  - VI.D.3.b).(1) **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.**
  - VI.D.3.b).(2) **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.**
- VI.D.3.c) **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**
- VI.D.4. **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.**
  - VI.D.4.a) **The program director must evaluate each fellow’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**
  - VI.D.4.b) **Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows.**
  - VI.D.4.c) **Fellows should serve in a supervisory role of residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual fellow.**
- VI.D.5. **Programs must set guidelines for circumstances and events in which fellows must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.**
  - VI.D.5.a) **Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.**

**VI.D.6.** Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility.

**VI.E. Clinical Responsibilities**

The clinical responsibilities for each fellow must be based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services.

**VI.F. Teamwork**

Fellows must care for patients in an environment that maximizes effective 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.

**VI.F.1.** Interprofessional teams may include non-physician health care professionals, e.g., medical assistants, specialized nurses, and technicians.

**VI.G. Fellow Duty Hours**

**VI.G.1. Maximum Hours of Work per Week**

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

**VI.G.1.a) Duty Hour Exceptions**

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

**VI.G.1.a).(1)** In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

**VI.G.1.a).(2)** Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

**VI.G.2. Moonlighting**

**VI.G.2.a)** Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program.

**VI.G.2.b)** Time spent by fellows in Internal and External Moonlighting

(as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

**VI.G.3. Mandatory Time Free of Duty**

Fellows must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

**VI.G.4. Maximum Duty Period Length**

Duty periods of fellows may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

**VI.G.4.a)** It is essential for patient safety and fellow education that effective transitions in care occur. Fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

**VI.G.4.b)** Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

**VI.G.4.c)** In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

**VI.G.4.c).(1)** Under those circumstances, the fellow must:

**VI.G.4.c).(1).(a)** appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

**VI.G.4.c).(1).(b)** document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

**VI.G.4.c).(2)** The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.

**VI.G.5. Minimum Time Off between Scheduled Duty Periods**

**VI.G.5.a) Fellows must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.**

Anesthesiology subspecialty fellows are considered to be in the final years of education.

**VI.G.5.a).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that fellows have eight hours free of duty between scheduled duty periods, there may be circumstances when these fellows must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.**

**VI.G.5.a).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by fellows must be monitored by the program director.**

VI.G.5.a).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the fellow has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

VI.G.5.a).(1).(c) Fellows in the final years of education may extend the eight-hour duty-free period when called upon to provide continuity of clinical care that is of critical importance to the patient and that provides unique educational value to the fellow.

VI.G.5.a).(1).(d) Exceptions to the eight-hour duty-free period must be determined in consultation with the supervising faculty member.

**VI.G.6. Maximum Frequency of In-House Night Float**

**Fellows must not be scheduled for more than six consecutive nights of night float.**

**VI.G.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).**

**VI.G.8. At-Home Call**

**VI.G.8.a) Time spent in the hospital by fellows on at-home call must count towards the 80-hour maximum weekly hour 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 duty, when averaged over four weeks.**

**VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow.**

**VI.G.8.b) Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.**

**VII. Peer Interaction**

Fellows should become experienced in teaching principles of pediatric anesthesiology, including topics such as management of patients requiring sedation outside the Operating Rooms, pain management, and life support, to other resident physicians, medical students, and other health care professionals. Fellows should also participate in planning and conducting conferences.

**VIII. Additional Required Components**

There should be prompt access to consultation with other disciplines, including pediatric subspecialties of neonatology, cardiology, neurology, pulmonology, radiology, critical care, emergency medicine, and pediatric subspecialties of surgical fields. To provide the necessary breadth of experience, an accredited residency training program in pediatrics is required within the institution. Residency programs or other equivalent clinical expertise in other specialties, particularly pediatric general surgery and pediatric surgical subspecialties, such as otolaryngology, cardiovascular surgery, urology, neurological surgery, ophthalmology, and orthopaedic surgery, and pediatric radiology are highly desirable.

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