Program Requirements for Graduate Medical Education in Obstetric Anesthesiology

One-year Common Program Requirements are in BOLD

Effective: October 1, 2011

Introduction

Intro.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.

Intro.B. Obstetric anesthesiology is the subspecialty of anesthesiology devoted to the comprehensive anesthetic management of women during pregnancy and the puerperium.

Intro.C. The educational program in obstetric anesthesiology must be 12 months in length.

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. The sponsoring institution must also sponsor ACGME-accredited residency programs in anesthesiology and obstetrics and gynecology.

I.A.2. There must be interaction between the anesthesiology residency and the fellowship which results in coordination of educational, clinical, and investigative activities.

I.B. Participating Sites

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 subspecialty by the American Board of** Anesthesiology**, or subspecialty qualifications that are acceptable to the Review Committee;**

II.A.2.c) **current medical licensure and appropriate medical staff appointment;**

II.A.2.d) current certification in Anesthesiology by the American Board of Anesthesiology;

II.A.2.e) completion of an obstetric anesthesiology fellowship, or at least three years' participation in a clinical obstetric anesthesiology fellowship as a program director or faculty member;

II.A.2.f) at least three years of post-residency experience in clinical obstetric anesthesiology;

II.A.2.g) current appointment as a member of the anesthesiology faculty; and,

II.A.2.h) demonstrated ongoing academic achievements appropriate to the subspecialty, including at least one of the following: publications, the development of educational programs, or the conduct of research.

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) devote at least 20% of his or her professional effort (academic, administrative, clinical, and educational time) to the fellowship program, included in a total of at least 50% of his or her professional effort devoted to the anesthetic care of obstetric women; and,

II.A.3.f) together with the core program director prepare and implement a supervision policy that specifies the lines of responsibility for the anesthesiology core residents and the fellows.

II.A.4. The program director must be based at the primary clinical site.

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.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. **The physician faculty must have current certification in Anesthesiology by the American Board of Anesthesiology.**

II.B.6. Physician faculty members must have fellowship education or post-residency experience in clinical obstetric anesthesiology.

II.B.7. Physician faculty members must demonstrate ongoing academic achievements appropriate to the subspecialty, including at least one of the following: publications, the development of educational programs, or the conduct of research.

II.B.8. Faculty members, including those in obstetrics and gynecology, and pediatrics, and non-anesthesiology faculty members with expertise in maternal and fetal medicine and neonatology, must be available for consultations and the collaborative management of peripartum patients, as well as instruction and supervision of fellows.

II.B.9. Faculty members certified in adult critical care must be available for consultation and collaborative management of peripartum women with critical care needs.

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.C.1. There must be specialized nursing staff for the care of the critically-ill newborn.

II.C.2. There must be allied health staff and other support personnel necessary for the comprehensive care of women during pregnancy.

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. Clinical facilities must include:

II.D.1.a) a designated area for labor and delivery which includes labor rooms, and cesarean/operative delivery rooms;

II.D.1.b) maternal and fetal monitoring and advanced life-support equipment;

II.D.1.c) a post-anesthesia care unit (PACU) or Labor-Delivery-Postpartum rooms designed and equipped for the collaborative management of post-operative obstetric patients by anesthesiologists and obstetrician-gynecologists; and,

II.D.1.d) a clinical laboratory that provides prompt and readily available diagnostic and laboratory measurements pertinent to the care of obstetric patients, including:

II.D.1.d).(1) blood chemistries;

II.D.1.d).(2) blood gases and pH;

II.D.1.d).(3) oxygen saturation;

II.D.1.d).(4) hematocrit and hemoglobin; and,

II.D.1.d).(5) coagulation function.

II.D.2. The patient population must include high-risk obstetric patients.

II.D.3. There must be an active maternal fetal medicine and neonatology service that is regularly involved in multidisciplinary care.

II.D.4. There must be facilities and space for the education of fellows, including meeting space, conference space, space for academic activities, and access to computers.

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.A.1. Prior to appointment in the program, fellows must have successfully completed an ACGME-accredited program in anesthesiology.

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. Fellows:

IV.A.2.a).(1) must demonstrate:

IV.A.2.a).(1).(a) technical expertise to perform all medical and invasive procedures relating to the area of obstetric anesthesiology;

IV.A.2.a).(1).(b) competence in the comprehensive analgesic/anesthetic management of deliveries, including:

IV.A.2.a).(1).(b).(i) planned vaginal deliveries with a high-risk maternal co-morbidity (at least 30 must be performed);

IV.A.2.a).(1).(b).(i).(a) This must include obtaining the appropriate diagnostic testing and consultation and communication with the multi-disciplinary team.

IV.A.2.a).(1).(b).(ii) planned vaginal deliveries with high-risk fetal conditions (at least 30 must be performed);

IV.A.2.a).(1).(b).(ii).(a) This must include appropriate interpretation of fetal surveillance and consultation with maternal-fetal medicine specialists and neonatologists as to the appropriate obstetric interventions and their timing.

IV.A.2.a).(1).(b).(iii) Cesarean deliveries with a high-risk

maternal co-morbidity (at least 30 must be performed); and,

IV.A.2.a).(1).(b).(iii).(a) This must include application of broad anesthetic principles and techniques in creating a comprehensive anesthetic care plan.

IV.A.2.a).(1).(b).(iii).(b) This must include collaborative management between anesthesiologists and obstetricians of women with abnormal placentation.

IV.A.2.a).(1).(b).(iv) Cesarean deliveries with a high-risk fetal condition (at least 20 must be performed).

IV.A.2.a).(1).(b).(iv).(a) This must include interpretation of fetal surveillance and consultation with maternal-fetal medicine specialists and neonatologists as to the appropriate obstetric interventions and their timing.

IV.A.2.a).(1).(c) competence to manage anesthetics during the first, second, or third trimesters, other than for Cesarean delivery, including antepartum procedures involving prenatal diagnosis and fetal treatment, maternal cardioversion, or electroconvulsive therapy (at least 10 must be performed overall);

IV.A.2.a).(1).(c).(i) This must be limited to no more than five cases accrued from cervical cerclage placement or removal).

IV.A.2.a).(1).(c).(ii) This must include: assessment of fetal status and possible maternal co-morbidity; development of an anesthetic care plan that is integrated with the surgical and obstetric care plan and that includes provision for peri-operative fetal monitoring; development of a plan for possible emergency Cesarean delivery if appropriate; provision for post-operative analgesia; and collaboration between anesthesiologists and obstetricians in the development of a plan to prevent preterm birth.

IV.A.2.a).(1).(d) competence to manage general anesthetics for Cesarean or vaginal delivery;

IV.A.2.a).(1).(d).(i) This must include: recognizing indications for general anesthesia; efficiently and quickly allaying the anxiety of the mother and communicating the anesthetic care plan; appropriately assessing the airway; and rapidly assessing the clinical scenario and its urgency in concert with the obstetric specialist and making the clinical judgment to initiate general anesthesia after considering the maternal and fetal risks.

IV.A.2.a).(1).(e) proficiency and skill preparing for and providing care, including developing a care plan, which acknowledges the patient's birth plan goals; and,

IV.A.2.a).(1).(f) proficiency in the anesthesia critical care of women during the puerperium.

IV.A.2.a).(2) must have completed a course in neonatal resuscitation through the American Academy of Pediatrics/American Heart Association (AAP/AHA) Neonatal Resuscitation Program, and must have received a course completion certificate prior to completion of the fellowship.

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:

IV.A.2.b).(1) must demonstrate competence in their knowledge, with specific emphasis on the anesthetic implications of the altered maternal physiologic state, the impact of interventions on the mother and fetus/neonate, and the care of the high-risk pregnant patient, of the following areas:

IV.A.2.b).(1).(a) advanced maternal physiology, biochemistry (nitric oxide, prostaglandins), genetic predispositions, and polymorphisms;

IV.A.2.b).(1).(b) embryology and teratogenicity, including laboratory models and use of databases;

IV.A.2.b).(1).(c) fetal and placental physiology and pathophysiology, models of uteroplacental perfusion, and pharmacokinetics of placental transfer;

IV.A.2.b).(1).(d) neonatal physiology and advanced neonatal resuscitation;

IV.A.2.b).(1).(e)	medical disease and pregnancy, including hypertensive disorders, morbid obesity, respiratory disorders, cardiac disorders, gastrointestinal diseases, endocrine disorders, autoimmune disorders, hematologic and coagulation disorders, neurologic disorders, substance abuse, HIV infection, AIDS, and psychiatric diseases;
IV.A.2.b).(1).(f)	obstetric management of abnormal labor, management of urgent and emergent delivery, and trial of labor;
IV.A.2.b).(1).(g)	tocolytic therapy, the effects of genetics on preterm labor and response to tocolytics, and methods of tocolysis;
IV.A.2.b).(1).(h)	labor pain, including pain pathways, experimental models for studying pain of labor, biochemical mechanisms of labor pain, and modalities for treating labor pain;
IV.A.2.b).(1).(i)	local anesthetic use in obstetrics, including pregnancy-related effects on pharmacodynamics and pharmacokinetics; recognition and treatment of complications; lipid rescue of local anesthetic cardiotoxicity; effects on the fetus in different settings, including prematurity, asphyxia, fetal cardiovascular and neurological effects; and fetal drug disposition;
IV.A.2.b).(1).(j)	neuraxial opioid use in obstetrics, including prevention, recognition, and treatment of complications; effects on the fetus; and fetal/neonatal drug disposition;
IV.A.2.b).(1).(k)	regional anesthetic techniques, including recognition and treatment of complications, effect of genetic variations, and polymorphisms;
IV.A.2.b).(1).(l)	general anesthesia use in obstetrics, including recognition and treatment of complications, alternatives for securing the airway in pregnant women (anticipated/unanticipated difficult airway), consequences on utero-placental perfusion, and opposing maternal-fetal considerations regarding the use of general anesthesia;
IV.A.2.b).(1).(m)	anesthetic and obstetric management of obstetric complications and emergencies, including placental abruption, placenta previa, placenta accrete, vasa

	previa, uterine rupture, uterine atony, amniotic fluid embolism, and umbilical cord prolapse;
IV.A.2.b).(1).(n)	anesthetic and obstetric management of preeclampsia, including laboratory models for study of preeclampsia; etiology and epidemiology; pathophysiology; biomolecular and genetic changes; and postpartum care;
IV.A.2.b).(1).(o)	cardiopulmonary resuscitation (CPR) and advanced cardiac life support of the pregnant woman;
IV.A.2.b).(1).(p)	postpartum tubal ligation and timing, including global policies to ensure availability, regulatory and consent issues, ethics, obstetric considerations, counseling, and alternatives;
IV.A.2.b).(1).(q)	postpartum pain management in the parturient, including consequences of post-Cesarean delivery pain;
IV.A.2.b).(1).(r)	non-obstetric surgery during pregnancy, including laparoscopy and cardiorespiratory effects on the mother and fetus;
IV.A.2.b).(1).(s)	effects of maternal medications on breastfeeding, particularly effects of labor analgesia and postpartum analgesia;
IV.A.2.b).(1).(t)	antepartum and intrapartum fetal monitoring, including the application of ultrasonography, biophysical profile, electronic fetal heart monitoring, assessment of uterine contraction pattern and labor, and acid-base status of the fetus;
IV.A.2.b).(1).(u)	effects of general anesthesia on the mother and fetus, and the effects of fetal circulation and placental transfer on newborn adaptation;
IV.A.2.b).(1).(v)	related disciplines, particularly involving obstetrics, maternal and fetal medicine, and neonatology;
IV.A.2.b).(1).(w)	anesthetic management of ex-utero intrapartum treatment (EXIT) procedures with and without neonatal transfer to extracorporeal membrane oxygenation (ECMO) and anesthesia for fetal surgery;
IV.A.2.b).(1).(x)	transport and monitoring of critically-ill parturients and neonates within one hospital and between hospitals;

IV.A.2.b).(1).(y) organization and management of an obstetric anesthesia service, including health care delivery models, reimbursement, building a service, and regulatory agencies with jurisdiction;

IV.A.2.b).(1).(z) legal and ethical issues during pregnancy;

IV.A.2.b).(1).(aa) social issues, including domestic violence; discrimination; substance abuse; homelessness; and cultural, ethnic and economic barriers to safe anesthesia care, including strategies to mobilize system resources for disadvantaged women in those situations;

IV.A.2.b).(1).(bb) medical economics and public health issues of women during reproductive years as it applies to obstetric anesthesiology, including availability of obstetric analgesia, and Cesarean delivery rates;

IV.A.2.b).(1).(cc) maternal morbidity and mortality;

IV.A.2.b).(1).(dd) policies and procedures governing the labor and delivery unit, obstetric operating rooms, and the obstetric PACU, including the potential effects of societal, institutional, and governmental factors;

IV.A.2.b).(1).(ee) principles and ethics of research in pregnant women, their fetuses, and neonates;

IV.A.2.b).(1).(ff) processes involved in designing and implementing clinical trials; and,

IV.A.2.b).(1).(gg) research funding, including:

IV.A.2.b).(1).(gg).(i) applicable funding agencies;

IV.A.2.b).(1).(gg).(ii) components of a research budget, including direct and indirect costs; and,

IV.A.2.b).(1).(gg).(iii) funding procurement mechanisms.

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;

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

IV.A.2.c).(2).(a) Studies must include literature from perinatal medicine and pediatrics in addition to anesthesiology.

IV.A.2.c).(3) demonstrate the ability to be an educator in obstetric anesthesiology; and,

IV.A.2.c).(4) demonstrate competence in practice-based improvement by completing a project with at least one of the following goals:

IV.A.2.c).(4).(a) enhancing the fellow's engagement in multidisciplinary care of obstetric patients; or,

IV.A.2.c).(4).(b) improving patient safety as it applies to the fellow's practice of obstetric anesthesiology.

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.d).(1) Fellows must demonstrate the following communication skills in a multidisciplinary setting:

IV.A.2.d).(1).(a) effectively communicating with the perinatal health care team;

IV.A.2.d).(1).(b) effectively collaborating with all health care providers in all settings relevant to the comprehensive care of the pregnant woman, including the outpatient clinic, antepartum consultation, labor and delivery, operating rooms, the PACU, intensive care units, and the emergency department;

IV.A.2.d).(1).(c) effectively leading the anesthesia care team; and,

IV.A.2.d).(1).(d) effectively supervising clinical trainees, including medical students and residents, and providing constructive feedback.

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

Fellows must demonstrate a commitment to carrying out

professional responsibilities and an adherence to ethical principles.

IV.A.2.e).(1) Fellows must demonstrate the ability to work in a multidisciplinary environment, particularly the ability to have collegial and effective interactions with other members of the perinatal care team.

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 effectively call on other resources in the system to provide optimal health care.

Fellows must:

IV.A.2.f).(1) demonstrate competence in recognizing barriers and limitations in access to care for some patient populations, including Medicaid reimbursement for postpartum sterilization, and developing strategies to meet patient needs;

IV.A.2.f).(2) demonstrate the ability to provide cost-effective care that incorporates best practices;

IV.A.2.f).(3) demonstrate competence in developing policies, guidelines, standards, practice parameters, and quality management tools to ensure the public health of pregnant women; and,

IV.A.2.f).(4) participate in a system improvement based on the literature, quality improvement data, and patient and family satisfaction data.

IV.A.3. Curriculum Organization and Fellow Experiences

IV.A.3.a) The curriculum must be structured to include:

IV.A.3.a).(1) interpretation of fetal heart rate monitoring and demonstrated competency in the first three months of the program;

IV.A.3.a).(2) a minimum of seven months of operating room and labor and delivery clinical activity;

IV.A.3.a).(3) at least one contiguous two-week rotation in maternal-fetal medicine that includes experience in antepartum fetal testing and high-risk antepartum care;

IV.A.3.a).(4) at least one contiguous two-week rotation in neonatology

during which fellows provide routine neonatal evaluation and care; and,

IV.A.3.a).(5) at least three months designated for research or other well-defined scholarly activity, leading to new knowledge related to the required rotations.

IV.A.3.b) The didactic curriculum should be provided through lectures, conferences, facilitated self-learning, workshops, or simulation, and should supplement clinical experience.

IV.A.3.b).(1) Faculty members should be conference leaders in the majority of the sessions.

IV.A.3.b).(2) The didactic curriculum should include all topics listed as expected medical knowledge outcomes.

IV.A.3.b).(3) Additional didactic topics must include:

IV.A.3.b).(3).(a) the impact of different anesthetic and analgesic techniques on health care resources, including room allocation; staffing; and patient throughput; and,

IV.A.3.b).(3).(b) sound business practices and the direct and indirect costs of different obstetric analgesic and anesthetic techniques.

IV.B. Fellows' Scholarly Activities

IV.B.1. Each fellow should conduct or be substantially involved in a scholarly project related to the subspecialty which leads to both presentation at a national meeting, and publication.

IV.B.1.a) Fellows must have a faculty mentor overseeing the project.

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 must provide evaluations of each fellow's progress and competency to the program director at the end of three, six, and nine months of education.

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**

V.A.2.a) **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).(1) **document the fellow's performance during the final period of education, and**

V.A.2.a).(2) **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.2.a) These evaluations must include annual written confidential evaluations of faculty members by the fellows.

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.**

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.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 in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.**

Obstetric anesthesiology 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 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) 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.”

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