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

One-year Common Program Requirements are in BOLD

Effective: January 1, 2001

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

Anesthesiology critical care medicine is a subspecialty of anesthesiology devoted to the acute and long-term care of critically-ill patients with multiple organ system derangements.

Int.C. Duration of Training

Subspecialty training in anesthesiology critical care medicine shall consist of 12 months of full-time training, beginning after satisfactory completion of a core anesthesiology residency program. At least nine of the 12 months of training in anesthesiology critical care medicine must be spent in the care of critically-ill patients in intensive care units (ICUs). The remainder may be in clinical activities or research relevant to critical care.

Int.D. Objectives

The subspecialty program in anesthesiology critical care medicine must be structured to provide resources necessary to ensure optimal patient care while providing its fellows the opportunity to develop skills in clinical care and judgment, teaching, administration and research.

Exposure should be provided to a wide variety of clinical problems in adult and pediatric patients necessary for the development of broad clinical skills required for a subspecialist in critical care medicine.

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. Relationship to Core Program

I.A.1.a) Accreditation of a subspecialty training program in anesthesiology critical care medicine will be granted only when the program is in direct association with a core residency program in anesthesiology accredited by the Accreditation Council for Graduate Medical Education (ACGME).

I.A.1.a).(1) Therefore, subspecialty training in anesthesiology critical care medicine can occur only in an institution in which there is an ACGME-accredited residency program in anesthesiology, or in an institution related by formal integration agreement to the core program.

I.A.1.a).(2) If the program is not conducted within the institution that sponsors the core residency program, there must be an integration agreement between the core program institution and the facility in which the anesthesiology critical care medicine program is conducted.

I.A.1.a).(3) Rotations outside the institution in which the anesthesiology critical care medicine program is based should not exceed four months. (Refer to the Program Requirements for Graduate Medical Education in Anesthesiology for the definitions governing affiliated and integrated institutions.)

I.A.1.b) The subspecialty program must function in conjunction with the core program in anesthesiology. The lines of responsibility

between staffs in both the core program and the subspecialty program must be clearly delineated.

I.A.1.c) There must also be ACGME-accredited core residencies in general surgery and internal medicine.

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.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.4. The program director has responsibility for the teaching program in anesthesiology critical care medicine subject to the approval of the program director of the core residency training program in anesthesiology.

II.A.5. Medical Director

The program director of the critical care program must be the medical director or co-medical director of one or more of the critical care units in which the majority of the clinical training of the critical care program is required to take place, and s/he must be personally involved in clinical supervision and teaching of anesthesiology critical care residents and fellows in that unit.

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 specialty 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 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.5.a) the scholarship of *discovery,* as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;

II.B.5.b) the scholarship of *dissemination,* as evidenced by review articles or chapters in textbooks;

II.B.5.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.6. 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.7. There must be evidence of active participation by qualified anesthesiologists with a continuous and meaningful role in the subspecialty training program.

II.B.7.a) Faculty members involved in teaching fellows must possess expertise in the care of critically-ill patients. It is recognized that such expertise will often cross specialty boundaries emphasizing the importance of collegial relationships and consultation between the critical care medicine program director and faculty from other disciplines including, but not limited to, surgery and its subspecialties, internal medicine and its subspecialties, pediatrics, obstetrics and gynecology, pathology and radiology.

II.B.7.a).(1) Where appropriate, supervision and teaching by faculty members in these disciplines should be integrated into the teaching program for fellows in anesthesiology critical care medicine.

II.B.7.b) Anesthesiology faculty members with expertise in critical care must be involved in teaching fellows and these should equal two or more FTEs. A ratio of one FTE faculty member to two fellows shall be maintained.

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: Resources

There should be an institutional policy governing the educational resources committed to critical care programs assuring cooperation of all involved disciplines. Where more than one critical care program exists in an institution, it will be the responsibility of the institution to coordinate interdisciplinary requirements.

II.D.2. Intensive Care Units (ICUs)

Subspecialty training in anesthesiology critical care medicine will occur principally in areas of the hospital commonly characterized as ICUs. Such ICUs are capable of providing acute and long-term life support of patients with multiple organ system derangements. Examples of ICUs include, but are not limited to, multidiscipline, surgical, medical, neonatal and pediatric, high-risk pregnancy, neurosurgical, trauma and burn units. An ICU must be located in a designated area within the hospital and designed specifically for care of critically-ill patients.

II.D.3. Patient Population

In order to provide sufficient range of exposure, an ICU that averages a census of at least five patients for each fellow is recommended.

II.D.4. Support Services

II.D.4.a) Adequate numbers of specially trained nurses plus technicians with expertise in biomedical engineering and respiratory therapy must be available.

II.D.4.b) There should be readily available, at all times, facilities to provide laboratory measurements pertinent to care of critically-ill patients with multiple organ system derangements. These include, but are not limited to, measurement of blood chemistries, blood gases and pH, culture and sensitivity, toxicology, and analysis of plasma drug concentrations.

II.D.4.c) Facilities for special radiologic imaging procedures and echocardiography are essential.

II.D.4.d) Appropriate monitoring and life-support equipment must be readily available and representative of current levels of technology.

II.D.5. Library

Conveniently located library facilities, and space for research and teaching conferences in critical care medicine are essential. There must be a departmental library with adequate material relevant to critical care. This may be supplemented but not replaced by private faculty book collections and hospital and institutional libraries.

II.D.6. Space

Space for research and teaching conferences in critical care must be available.

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. Clinical Components

Each fellow must gain clinical experience in the following areas:

IV.A.3.a) airway maintenance and management;

IV.A.3.b) mechanical ventilation;

IV.A.3.c) devices which supply supplemental oxygen;

IV.A.3.d) indications of and techniques for emergency and therapeutic treatment of conditions requiring thoracentesis and/or tube thoracotomy;

IV.A.3.e) emergency and therapeutic fiberoptic Laryngotracheobronchoscopy;

IV.A.3.f) assessment and evaluation of pulmonary function;

IV.A.3.g) cardiopulmonary resuscitation;

IV.A.3.g).(1) Fellows must be certified in ACLS and ATLS prior to completion of their anesthesiology critical care medicine training. The program must provide access to this training.

IV.A.3.h) placement and management of arterial, central venous and pulmonary arterial catheters;

IV.A.3.i) emergency and therapeutic placement of pacemakers;

IV.A.3.j) pharmacologic and mechanical support of circulation;

IV.A.3.k) evaluation and management of central nervous system dysfunction;

IV.A.3.l) recognition and treatment of hepatic and renal dysfunction;

IV.A.3.m) diagnosis and treatment of sepsis;

IV.A.3.n) fluid resuscitation and management of massive blood loss;

IV.A.3.o) enteral and total parenteral nutrition;

IV.A.3.p) bioengineering and monitoring;

IV.A.3.q) interpretation of laboratory results;

IV.A.3.r) psychiatric effects of critical illness;

IV.A.3.s) transesophageal echocardiography (TEE); and,

IV.A.3.t) ethical aspects of critical care.

IV.A.4. Didactic Components

The teaching curriculum must include the following areas:

IV.A.4.a) resuscitation;

IV.A.4.b) cardiovascular physiology, pathology, pathophysiology, and therapy;

IV.A.4.c) respiratory physiology, pathology, pathophysiology, and therapy;

IV.A.4.d) renal physiology, pathology, pathophysiology, and therapy;

IV.A.4.e) eentral nervous system physiology, pathology, pathophysiology, and therapy;

IV.A.4.f) pain management of critically-ill patients;

IV.A.4.g) metabolic and endocrine effects of critical illness;

IV.A.4.h) infectious disease physiology, pathology, pathophysiology, and therapy;

IV.A.4.i) hematologic disorders secondary to critical illness;

IV.A.4.j) gastrointestinal, genitourinary, and obstetric-gynecologic acute disorders;

IV.A.4.k) trauma, including burns;

IV.A.4.l) monitoring, bioengineering, biostatistics;

IV.A.4.m) life-threatening pediatric conditions;

IV.A.4.n) end-of-life care;

IV.A.4.o) pharmacokinetics and dynamics; drug metabolism and excretion in critical illness;

IV.A.4.p) transport of critically-ill patients;

IV.A.4.q) administrative and management principles and techniques;

IV.A.4.r) medical informatics;

IV.A.4.s) cost-effective care;

IV.A.4.t) ethical and legal aspects; and,

IV.A.4.u) effective interpersonal and communication skills with patients, family members, and other health care providers.

IV.A.5. Consultation

In preparation for roles as consultants to other specialists, each fellow must have the opportunity to provide consultation under the direction of faculty members responsible for teaching in the anesthesiology critical care medicine program.

IV.A.6. ICU Administration

Fellows should gain experience in the administration of an ICU as related to appointment and training of non-physician personnel, establishment of policies regulating functioning of the ICU, and coordination of the activities of the ICU with other in-hospital units.

IV.A.7. Conferences

Subspecialty conferences, including mortality and morbidity conferences, journal reviews and research seminars, must be regularly scheduled. Active participation by each fellow in the planning and production of these conferences is essential. Attendance at multidisciplinary conferences is encouraged, with particular attention given to those conferences relevant

to critical care medicine.

IV.B. Fellows' Scholarly Activities

Each program must provide an opportunity for fellows to participate in research or other scholarly activities, and fellows must participate actively in such scholarly activities.

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 trainee's progress and competence to the program director at the end of six months and 12 months of training. These evaluations should include intellectual abilities, manual skills, attitudes and interpersonal relationships, as well as specific tasks of patient management, decision-making skills and critical analysis of clinical situations. Each fellow must achieve an overall satisfactory evaluation at 12 months to receive credit for training. There must be written feedback of these evaluations to each fellow.

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. Written and confidential evaluations of critical care medicine faculty member performance by each fellow must take place once a year.

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. Written evaluations of patient care and subspecialty training objectives are required annually.

V.C.4. Board Certification

One measure of the quality of a program is the record of its graduates in obtaining certification in critical care by the American Board of Anesthesiology. The Review Committee will consider this information as part of the overall evaluation of the program.

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) 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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