

ACGME Program Requirements for Graduate Medical Education in Orthopaedic Sports Medicine

One-year Common Program Requirements are in BOLD

Effective: July 1, 2008

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. Orthopaedic sports medicine is the component of orthopaedic surgery that is focused on the study and prevention of sports injuries and their treatment by medical, surgical, and physical methods.

Int.C. Postgraduate fellowship education in orthopaedic surgery is a component in the continuum of the educational process, and such education should take place after completion of an accredited residency. Graduate medical education programs in the subspecialties of orthopaedic surgery will be accredited to offer 12 months of education.

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. Postgraduate fellowship programs in the subspecialties of orthopaedic surgery may be accredited in institutions that sponsor accredited residency programs in orthopaedic surgery or that are affiliated with an orthopaedic surgery residency accredited by the Accreditation Council for Graduate Medical Education (ACGME). Requests for exceptions to this policy will be reviewed on a case-by-case basis.
- I.A.2. When orthopaedic residents and fellows are being educated in the same institution, the residency director and the fellowship director must jointly prepare and approve a written agreement specifying the educational relationship between the residency and fellowship programs, the roles of the residency and fellowship directors in determining the educational program of residents and fellows, and the roles of the residents and fellows in patient care.
- I.A.3. There must be close monitoring of the interface between residency and fellowship education. It is imperative that orthopaedic fellowship education not interfere with the education of residents. Lines of responsibility for the orthopaedic resident and the fellow must be clearly defined. In addition, the fellow should maintain a close working relationship with orthopaedic residents and other fellows in orthopaedic surgery and in other disciplines.
- I.A.4. Programs must provide an intellectual environment for acquiring the knowledge, skills, clinical judgment, and attitudes essential to the practice of orthopaedic sports medicine. This objective can be achieved only when the program director, the supporting faculty and staff, and the administration are fully committed to the educational program and when appropriate resources and facilities are present. Effective graduate education is not achieved when the educational program functions primarily to meet service commitments.

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 GMCEC 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 Orthopaedic Surgery, 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 GMCEC/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.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) There must be at least two physician faculty members with experience in sports medicine who are actively involved in the instruction and supervision of fellows during the 12 months of accredited education.
 - 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 Orthopaedic Surgery, 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.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. A sufficient number of new and follow-up patients must be available to ensure adequate inpatient and outpatient experience for each fellow without adversely diluting the educational experience of the orthopaedic surgery residents or the educational experience of residents in other specialties.

II.D.2. Facilities to accomplish the clinical and educational objectives of the specialty must be available and functioning for both inpatients and outpatients.

II.D.2.a) The physical therapy and the athletic training departments should be completely equipped with the modern therapeutic modalities used in the treatment of the injured athlete.

II.D.2.b) The operating room facilities must contain modern equipment, including arthroscopes, adjunctive equipment for arthroscopy, and necessary imaging equipment.

II.D.3. The educational program must be conducted in a setting that will allow interaction with the disciplines of radiology, physical therapy, internal medicine, and such other specialties ordinarily encountered in sports medicine.

II.D.4. Library services should include the electronic retrieval of information from medical databases.

II.D.5. There must be an on-site library or a collection of appropriate texts and journals in each institution participating in the program. On-site libraries and/or collections of texts and journals must be readily available during nights and weekends.

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. The program should be committed to promoting the inclusion of qualified women and under-represented minorities in the profession through its recruiting.

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. Didactic Components

IV.A.3.a) The academic component must emphasize a scholarly approach to clinical problem solving, self-directed study, teaching, development of analytic skills and surgical judgment, and research.

IV.A.3.b) All fellows must participate in didactic sessions devoted to the basic sciences, including anatomy, biomechanics, and biology of healing.

IV.A.3.c) Instruction should also be provided in sports medicine issues in the areas of cardiology, dermatology, pulmonology, preventive medicine, pediatric and adolescent medicine, exercise physiology, environmental exposure, athletic populations, team physicians, and protective equipment (including braces).

IV.A.3.d) Didactic activity should include the evaluation of practices that ensure and improve patient safety as well as instruction in established patient safety measures.

- IV.A.4. Clinical Components
- IV.A.4.a) The clinical component must be designed to ensure that fellows become competent in the evaluation (history, physical examination, and imaging) and management (both operative and non-operative) of patients with sports injuries or conditions.
- IV.A.4.b) The program must offer supervised training in the operative and other technical skills integral to orthopaedic sports medicine. Instruction and experience must be sufficient for the fellow to understand the indications, risks, and limitations of the commonly performed procedures in the subspecialty.
- IV.A.4.c) Fellows must have the opportunity to provide consultation with faculty supervision and should have clearly defined educational responsibilities for residents, medical students and allied health personnel. These teaching experiences should correlate basic biomedical knowledge with the clinical aspects of the subspecialty.
- IV.A.4.d) Clinical experience must include inpatient and outpatient opportunities to observe, manage, operate and follow patients with a wide variety of sports medicine problems.
- IV.A.4.e) The program must be structured to provide the fellow with an opportunity to assume continuing responsibility with appropriate supervision for patients with acute and chronic injuries and to observe the natural course of athletic injuries and the effects of various therapeutic modalities on their outcome. Fellow education must provide sufficient opportunity for independent clinical decision making so that the program director and faculty members are ensured that the graduating fellow has achieved the ability to make sound clinical decisions.
- IV.A.4.f) The program must provide the fellow with the opportunity to work with athletic teams and/or athletic organizations.
- IV.A.4.g) The program must emphasize the pathology and biomechanics of athletic injuries and the effects of injury on the athlete, including both physical and psychological manifestations. Appropriate utilization of laboratory tests, physical modalities, and operative procedures for the diagnosis and treatment of athletic injuries must be stressed.
- IV.A.4.h) The program must provide the fellow with specific experience with athletic training and physical therapy.
- IV.A.4.i) The program must provide sufficient opportunity for the fellow to gain knowledge and skill in a number of areas that include, but are not limited to:
- IV.A.4.i).(1) taking a history and performing an appropriate physical

- examination for orthopaedic sports injuries;
- IV.A.4.i).(2) exposure to patients with typical histories and physical findings of chronic orthopaedic sports injuries and the management of those injuries;
- IV.A.4.i).(3) differentiating between those sports injuries that require immediate surgical treatment and those that can be treated nonoperatively;
- IV.A.4.i).(4) recognizing those sports injuries for which a minor delay in treatment would not be deleterious to the patient;
- IV.A.4.i).(5) acute care of orthopaedic and other acute sports medicine injuries that may occur during athletic competition and how to deal with those injuries on the athletic field;
- IV.A.4.i).(6) how to order and interpret radiologic examinations that are used for diagnosis of sports injuries, including specific views, tomograms, bone scans, arthrograms, computerized axial tomography scans, and magnetic resonance imaging;
- IV.A.4.i).(7) therapeutic modalities offered in the department of physical therapy, how to use them, and how to judge the appropriateness and efficacy of a treatment plan;
- IV.A.4.i).(8) diagnostic and operative arthroscopy;
- IV.A.4.i).(9) non-orthopaedic problems that occur in sports medicine and how to deal with those problems or how to refer them appropriately;
- IV.A.4.i).(10) the psychological effect of injuries on athletes and how to deal with them personally and how to select consultants to assist in their management; and,
- IV.A.4.i).(11) sports equipment, particularly protective devices intended to allow the athlete to continue to compete, including helmets, protective pads, knee braces, foot orthotics, and others not specifically named.

IV.B. Fellows' Scholarly Activities

- IV.B.1. Fellows must participate in basic and/or clinical hypothesis based research.
- IV.B.2. Fellows must learn to design, implement, and interpret research studies under supervision by qualified faculty members.
- IV.B.3. The program must provide scheduled and protected time and facilities for

research activities by fellows.

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.b) The faculty 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.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.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 the 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.

A licensed independent practitioner may include non-physician faculty working in conjunction with the orthopaedic surgery department.

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

Fellows in the subspecialties of orthopaedic surgery 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.6.

Maximum Frequency of In-House Night Float

VI.G.7.

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

VI.G.7.a)

Night float may not exceed three months per year.

VI.G.8.

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.9.

At-Home Call

VI.G.9.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.9.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.9.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".

ACGME Approved: September 11, 2007 Effective: July 1, 2008

Editorial Revision: July 1, 2009

Revised Common Program Requirements Effective: July 1, 2011