

ACGME Program Requirements for Graduate Medical Education in Pediatric Otolaryngology

One-year Common Program Requirements are in BOLD

Effective: July 1, 2006

Introduction

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

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

Int.B. Definition and Scope of the Specialty

Pediatric otolaryngology is a subspecialty within otolaryngology defined by both the age of the patient served and the knowledge and skill of the physician providing medical and surgical care. The pediatric otolaryngologist has an advanced education and experience, beyond that afforded in otolaryngology residency, in the management of neonates and children with complex otolaryngologic problems and significant co-morbidities, generally referred to tertiary care pediatric institutions. A pediatric otolaryngology educational program will be based in a tertiary care pediatric institution where the care of neonates and children can be readily coordinated with other subspecialists, thus allowing sufficient exposure and broad experience, beyond that afforded otolaryngology residency, in the management of uncommon and complex otolaryngologic disorders in high risk neonates and children who may have a variety of significant co-morbidities.

A pediatric otolaryngology educational program must provide the following

experiences for the pediatric otolaryngology fellows: the diagnosis and care of uncommon and complex congenital and acquired conditions involving the aerodigestive tract, nose and paranasal sinuses, the ear, diseases and disorders of the laryngotracheal complex and the head and neck; expertise in the diagnosis, treatment, and management of childhood disorders of voice, speech, language, and hearing; and a knowledge of genetics. The program should provide opportunities for the fellow to function as an advocate for the child and facilitate patient management in the home, school, or institutional setting.

Int.C. Duration and Scope of Education

Int.C.1. Admission prerequisites:

Admission to a pediatric otolaryngology program is contingent on satisfactory completion of a residency program in otolaryngology accredited by either the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada.

Int.C.2. Length of program:

Programs will be accredited to provide 12 months of education in pediatric otolaryngology, all of which must be spent in participating institutions approved by the Review Committee. The pediatric otolaryngology program must be associated with an ACGME-accredited otolaryngology program.

Int.C.3. Specific description of program format:

A minimum of one pediatric otolaryngology fellow should be enrolled. A program without a fellow for four successive years will be administratively withdrawn.

Int.C.4. Policy/procedure for notifying fellows:

Prior to entry into the program, each fellow must be notified in writing of the required length of the program.

I. Institutions

I.A. Sponsoring institution

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

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

I.A.1. A pediatric otolaryngology educational program must be associated with a

general otolaryngology program in good standing and sponsored by a single sponsoring institution, as stated in the Institutional Requirements. In addition, the program must be based within a pediatric tertiary care institution that provides sufficient exposure and broad experience, beyond that afforded in otolaryngology residency, in the management of children and neonates with uncommon and complex otolaryngic disorders, with or without significant co-morbidities.

I.A.2. The sponsoring institution must provide sufficient faculty, clinical material, research, and other educational resources to meet the needs of the fellows.

I.A.3. Service commitments must not compromise the achievement of educational goals and objectives.

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).

I.B.3. Assignment at participating sites should provide resources not otherwise available to the program.

I.B.4. Assignments at participating sites must be of sufficient length to ensure a quality educational experience and should provide sufficient opportunity for continuity of care. Although the number of participating sites may vary with the various specialties' needs, all participating sites must demonstrate the ability to promote the program goals and educational and peer activities.

I.B.5. The Review Committee must approve the addition or deletion of all participating sites prospectively. Such approval will be based on a clear educational rationale and the value of the site to the program.

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 certified in the specialty by the American Board of Otolaryngology, or specialty qualifications that are acceptable to the Review Committee; and,

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

II.A.2.c).(1) The program director must be licensed to practice medicine in the state where the institution that sponsors the program is located and must be appointed in good standing to the medical staff of an institution participating in the program.

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 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 withdrawal 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) develop a sound administrative and organizational framework that includes an effective faculty as an essential element of the program. Continuity of leadership is essential to the program's stability. Frequent changes in leadership or long periods of temporary leadership will be cause for serious concern;

- II.A.3.f) devote sufficient time to the program to ensure continuity of leadership and to fulfill all the responsibilities inherent in meeting the educational goals of the program;

- II.A.3.g) maintain a record of pediatric otolaryngology operative cases using the ACGME data collection system which includes a record of operative experience which includes a record of operative experience for each pediatric otolaryngology fellow. These records must be reviewed at least semiannually by the program director as a part of his or her responsibility for evaluation of the balanced progress of each individual fellow and of the total program. These data must be submitted to the Review Committee at the time of each program review;

- II.A.3.h) prepare a written statement outlining the educational goals of the

program with respect to the knowledge, skills, and other attributes of fellows at each level of education and for each major rotation or other program assignment. This statement must be distributed to fellows and members of the faculty and be readily available for review;

- II.A.3.i) select fellows for appointment to the program in accordance with institutional and departmental policies and procedures;
- II.A.3.j) select and supervise faculty members and other personnel at each institution participating in the program;
- II.A.3.k) supervise fellows through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines must be communicated to all members of the faculty. Fellows must be provided with prompt, reliable systems for communication and interaction with supervising physicians; and,
- II.A.3.l) develop a structured curriculum with written, defined goals and objectives. Clinical, basic science, research conferences and seminars, and journal club activities pertaining to the subspecialty must be conducted regularly. Fellows must participate in planning and conducting the conferences. Both the faculty and the fellow must attend and participate in multidisciplinary conferences.

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.2.a) One measure of this commitment is the extent to which faculty members permit fellows to participate in the management of patients under their care.
- II.B.3. The physician faculty must have current certified in the sub specialty by the American Board of Otolaryngology, or possess qualifications acceptable to the Review Committee.**
 - II.B.3.a) Faculty members must possess training in the subspecialty of pediatric otolaryngology.
- II.B.4. The physician faculty must have 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.C.1. Because the care of pediatric otolaryngology patients may be multidisciplinary in nature, additional peers from pediatrics and other related pediatric disciplines should participate in the program to enhance the fellows' educational opportunities. Examples of related faculty may include anesthesiology, medical genetics, radiology, neonatology, sleep medicine, behavioral pediatric and child psychiatry, pulmonology, pediatric neurology, audiology, speech, voice, and hearing specialists, prenatal and fetal medicine, plastic surgery and pathology.

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. The course of study must include research methodology, not to exceed six months, with protected time for the pursuit of scholarly activities and research.
- II.D.2. The fellow should study epidemiology, statistical methods, experimental design, and manuscript preparation, including literature search and the use of computerized databases.
- II.D.3. Complete diagnostic facilities for infants and children with otolaryngologic disorders must be available to provide the fellow with the opportunity to interpret the results of diagnostic studies.
- II.D.4. The diagnostic procedures and techniques for complete audiologic, voice, speech, language, and developmental assessments must be available. In addition, state-of-the-art diagnostic, therapeutic, and laboratory facilities must be provided.
- II.D.5. Library
- II.D.5.a) Fellows must have ready access to a major medical library, either at the institution where the fellows are located or through arrangements with convenient nearby institutions.
- II.D.5.b) Library services should include the electronic retrieval of information from medical databases.
- II.D.5.c) There must be access to an on-site library or to collections of appropriate texts and journals in each institution participating in the educational program.
- II.D.6. There must be a sufficient number and variety of surgical cases to provide the fellow with operative experience in all aspects of pediatric otolaryngology.

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 Appointment

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.

III.B.1. The program may not graduate more fellows in any year than are approved by the Review Committee unless prior approval has been received.

III.B.2. The appointment of other fellows requires a clear statement of the areas of training, clinical responsibilities, and duration of the special education. This statement must be supplied to the Review Committee at the time the program is site visited.

III.B.3. If such fellows so appointed will, in the judgment of the Review Committee, detract from the education of the regularly appointed otolaryngology residents, the accreditation status of the program may be adversely affected.

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)

should have a surgical case load that includes experience in the following areas: laryngology and bronchoesophagology, head and neck surgery, care for patients with comorbidities, laryngotracheal surgery, otologic surgery, surgery of the nose and paranasal sinuses, surgery for congenital abnormalities of the head and neck, and surgery for benign and malignant head and neck disorders;

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

must have outpatient experiences; and,

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

Outpatient experiences must be provided with adequate experiences, and a sufficient number of visits for the evaluation of patients with varied types of disorders, in order to provide the fellows with wide experience in diagnosis and outpatient management of patients with complex and uncommon otolaryngologic disorders. Fellows are required to attend a minimum of one clinic session per week.

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

Outpatient experiences should occur in the ambulatory care setting and the experience must include evaluation of children with complex and uncommon disorders and experience with the diagnosis and management of children with congenital abnormalities of the head and neck, hearing impairment, inherited disorders and developmental abnormalities, swallowing disorders, and sinus disease.

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

Outpatient experiences should be provided with a multispecialty, interdisciplinary team experience to include, for example, craniofacial, cleft palate, or cochlear implant team.

IV.A.2.a).(3)

must have inpatient experiences.

IV.A.2.a).(3).(a)

Fellows must have their educational experiences in an adequate inpatient facility and one that provides a broad range of pediatric consultative experience; pediatric intensive care facilities must be available for the fellows' experience.

IV.A.2.a).(3).(b)

Knowledge, manual skill, experience, and the complexity of the patient's illness and the degree of surgical risk will determine the responsibilities and independence given to fellows in patient care.

IV.A.3. 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.4. Practice-based Learning and Improvement

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

IV.A.4.a) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; and,

IV.A.4.b) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.

IV.A.5. 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.5.a) Fellows must be provided with opportunities to develop skills in providing consultation, in communicating with colleagues and referring physicians, and in teaching and supervising medical students, fellows, physicians, and other professional personnel.

IV.A.5.b) Lines of responsibility must be clearly defined between pediatric otolaryngology and otolaryngology fellows in the areas of education, clinical responsibilities, and duration of education. Such information must be supplied to the Review Committee at the time of the survey and review.

IV.A.6. Professionalism

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

IV.A.7. 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.B. Fellows' Scholarly Activities

- IV.B.1. Graduate medical education must take place in an environment of inquiry and scholarship in which pediatric otolaryngology fellows are encouraged to participate in the development of new knowledge, learn to evaluate research findings, and develop habits of inquiry as a continuing professional responsibility. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty.
- IV.B.2. The educational program must provide an intellectual environment for acquiring the knowledge, skills, clinical judgment, and attitudes that are essential for the practice of the subspecialty. This objective can be achieved only when the program leadership, the faculty, and the sponsoring institution are committed to the educational program and when appropriate resources and facilities are available.
- IV.B.3. The program must outline its educational goals with respect to the knowledge and skills beyond those afforded in otolaryngology residency, for the care of uncommon and complex ear, nose, throat, head and neck, and bronchoesophageal disorders of infants and children with significant co-morbidities.
- IV.B.4. The overall goal for fellowship education is to provide the pediatric otolaryngology fellow with diagnostic medical and surgical skills for ear, nose, throat, head and neck, and bronchoesophageal disorders of children.
- IV.B.5. Specific objectives include:
- IV.B.5.a) an in-depth study of the embryology, developmental anatomy and physiology, microbiology, oncology, and psychology of the infant and child as related to the head and neck;
 - IV.B.5.b) an understanding of the differences with regard to the medical management of infant, childhood, and adult diseases of the head and the neck;
 - IV.B.5.c) The provision for a sufficient number and variety of pediatric otolaryngology surgical procedures in the scope of the specialty with emphasis on those complex and uncommon procedures which are infrequently encountered in the general practice of otolaryngology, as well as medical and surgical treatment of neonates and children with significant co-morbidities;
 - IV.B.5.d) an appreciation for the inherent complexities of interacting and counseling with children and their families compared with adult patients; and
 - IV.B.5.e) the opportunity to teach otoscopic and other diagnostic skills to

pediatricians and other primary care physicians.

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 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,

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

V.A.2.c) include a list of all surgical operative procedures performed by the fellow during the fellowship program, and,

V.A.2.d) be accessible to the program director through the ACGME and kept in a permanent file for inspection by the Review Committee at the time of the site visit and program review.

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.

V.C.3. The faculty should periodically evaluate the utilization of resources available to the program, the contribution of each participating institution, the financial and administrative support for the program, the volume and variety of patients available to the program for educational purposes, the performance of members of the faculty, and the quality of fellow supervision.

V.C.4. The faculty must be organized and have regular documented meetings to review program goals and objectives and program effectiveness in achieving them. At least one fellow should participate in these reviews.

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.E.1. The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge. During the residency education process, surgical teams should be made up of attending surgeons, residents at various PGY levels, medical students (when appropriate), and other health care providers. The work of the caregiver team should be assigned to team members based on each individual's level of education, experience, and competence.

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. Effective surgical practices entail the involvement of members with a mix of complementary skills and attributes (physicians, nurses, and other staff). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care.

VI.F.2. Fellows must collaborate with fellow surgical residents, and with especially faculty, other physicians outside of their specialty, and non-traditional health care providers to best formulate treatment plans for an increasingly diverse patient population.

VI.F.3. Fellows must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed within the hours assigned, or, if that is not possible, fellows must learn and utilize the established methods for handing off remaining tasks to another member of the fellow team so that patient care is not compromised.

VI.F.4. Lines of authority should be defined by programs, and all fellows must have a working knowledge of expected reporting relationships to maximize quality care and patient safety.

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.
- Pediatric otolaryngology 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.

