

1 **ACGME Program Requirements for Graduate Medical Education**  
2 **in Surgical Critical Care**

3  
4 **One-year Common Program Requirements are in BOLD**

5  
6 Effective: July 1, 2012  
7

8 **Introduction**

9  
10 **Int.A. Residency and fellowship programs are essential dimensions of the**  
11 **transformation of the medical student to the independent practitioner along**  
12 **the continuum of medical education. They are physically, emotionally, and**  
13 **intellectually demanding, and require longitudinally-concentrated effort on**  
14 **the part of the resident or fellow.**

15  
16 **The specialty education of physicians to practice independently is**  
17 **experiential, and necessarily occurs within the context of the health care**  
18 **delivery system. Developing the skills, knowledge, and attitudes leading to**  
19 **proficiency in all the domains of clinical competency requires the resident**  
20 **and fellow physician to assume personal responsibility for the care of**  
21 **individual patients. For the resident and fellow, the essential learning**  
22 **activity is interaction with patients under the guidance and supervision of**  
23 **faculty members who give value, context, and meaning to those**  
24 **interactions. As residents and fellows gain experience and demonstrate**  
25 **growth in their ability to care for patients, they assume roles that permit**  
26 **them to exercise those skills with greater independence. This concept—**  
27 **graded and progressive responsibility—is one of the core tenets of**  
28 **American graduate medical education. Supervision in the setting of**  
29 **graduate medical education has the goals of assuring the provision of safe**  
30 **and effective care to the individual patient; assuring each resident’s and**  
31 **fellow’s development of the skills, knowledge, and attitudes required to**  
32 **enter the unsupervised practice of medicine; and establishing a foundation**  
33 **for continued professional growth.**

34  
35 **Int.B. Definition and Scope of the Subspecialty**

36  
37 **Int.B.1. Surgical critical care deals with is a subspecialty of surgery that manages**  
38 **complex surgical and medical problems in critically-ill surgical patients.**  
39 **Institutions sponsoring Graduate educational programs in surgical**  
40 **critical care must provide the educational, clinical, and administrative**  
41 **resources to allow fellows to develop advanced proficiency in the**  
42 **management of critically-ill surgical patients, to develop the qualifications**  
43 **necessary to supervise surgical critical care units, and to conduct**  
44 **scholarly activities in surgical critical care. The educational programs**  
45 **must enhance and be are an integral part of an Accreditation Council for**  
46 **Graduate Medical Education (ACGME)-accredited core program in**  
47 **general-surgery.**

48  
49 **Int.B.2. The goal of a surgical critical care fellowship program is to prepare the**  
50 **fellow to function as a qualified practitioner at the advanced level of**  
51 **performance expected of a Board-certified subspecialist. The education of**

52 surgeons in the practice of surgical critical care encompasses didactic  
53 instruction in the basic and clinical sciences of surgical diseases and  
54 conditions, as well as education in procedural skills and techniques used  
55 in the intensive care settings. This educational process leads to the  
56 acquisition of an appropriate fund of knowledge and technical skills, the  
57 ability to integrate the acquired knowledge into the clinical situation, and  
58 the development of judgment.

59  
60 Int.B.2. ~~Subspecialty educational program requirements in surgical critical care~~  
61 ~~are in addition to the requirements for critical care education set forth in~~  
62 ~~the core program requirements. There should be an institutional policy~~  
63 ~~governing the educational resources committed to critical care programs~~  
64 ~~and ensuring cooperation of all involved disciplines.~~

65  
66 Int.B.3. ~~Residents in general surgery, neurosurgery, urology, or obstetrics and~~  
67 ~~gynecology who enter the program prior to completing a residency must~~  
68 ~~have a categorical residency position in their specialty available to them~~  
69 ~~on satisfactory completion of the critical care fellowship.~~

70  
71 Int.C. ~~Duration and Scope of Education~~

72  
73 Int.C.1. ~~The educational program in length of the surgical critical care must be~~  
74 ~~educational program is 12 months in length, of which two months may be~~  
75 ~~elective rotations. These 12 months must be devoted to advanced~~  
76 ~~educational and clinical activities related to the care of critically ill patients~~  
77 ~~and to the administration of critical care units.~~

78  
79 Int.C.2. ~~In some instances, fellows may devote up to 25% of their time to direct~~  
80 ~~operative care of critically ill patients. During such operative care, the~~  
81 ~~critical care fellow and chief resident in general surgery may not share~~  
82 ~~primary responsibility for the same patient. However, in the nonoperative~~  
83 ~~management of critically ill surgical patients, the surgical critical care~~  
84 ~~fellows and general surgery residents may interact as long as they share~~  
85 ~~primary responsibility in patient management decisions. The final decision~~  
86 ~~and responsibility rests with the supervising attending surgeon.~~

## 87 88 I. Institutions

### 89 90 I.A. Sponsoring Institution

91  
92 **One sponsoring institution must assume ultimate responsibility for the**  
93 **program, as described in the Institutional Requirements, and this**  
94 **responsibility extends to fellow assignments at all participating sites.**

95  
96 **The sponsoring institution and the program must ensure that the program**  
97 **director has sufficient protected time and financial support for his or her**  
98 **educational and administrative responsibilities to the program.**

99  
100 I.A.1. The sponsoring institution must provide the program director with a  
101 minimum of 10% protected time or direct salary support or indirect salary  
102 support, such as release from clinical activities.

- 103  
104 I.A.2. The sponsoring institution must also Fellowship education programs in  
105 surgical critical care may be accredited only in institutions which either  
106 sponsor an ACGME-accredited residency education program in general  
107 surgery, or pediatric surgery, thoracic surgery, or vascular surgery, or are  
108 integrated by formal agreement into such programs.  
109
- 110 I.A.2.a) There must be interaction between the core residency program in  
111 surgery, pediatric surgery, thoracic surgery, or vascular surgery  
112 and the fellowship program which results in coordination of  
113 educational, clinical, and investigative activities.  
114
- 115 I.A.3. Any institution that sponsors more than one critical care program must  
116 coordinate interdisciplinary requirements ~~When more than one critical~~  
117 ~~care program, exists in an institution, it is the responsibility of that,~~  
118 ~~institution to coordinate interdisciplinary requirements to ensure that~~  
119 ~~fellows meet the specific criteria of their primary specialties, e.g., surgery,~~  
120 ~~medicine, and anesthesiology.~~  
121
- 122 I.A.4. ~~A surgical critical care program must include primary educational~~  
123 ~~activities in a surgical critical care unit with pediatric and/or adult patients,~~  
124 ~~located in an institution that has been approved by the Review Committee~~  
125 ~~as an integrated institution with a core general surgery or pediatric~~  
126 ~~surgery residency program. The education may take place in various~~  
127 ~~settings that provide for the care of critically ill adult and/or pediatric~~  
128 ~~surgical patients, including those with general surgical conditions such as~~  
129 ~~trauma, burns, and surgical oncology; with cardiothoracic, neurosurgical,~~  
130 ~~and high-risk pregnancy conditions; and with organ transplantation.~~  
131
- 132 I.A.5. It is ~~desirable~~ strongly suggested that the sponsoring institution ~~have also~~  
133 sponsor ACGME-accredited residency programs in surgery and the  
134 surgical specialties, as well as in those specialties that relate particularly  
135 to surgery, such as anesthesiology, diagnostic radiology, internal  
136 medicine, and pathology.  
137
- 138 **I.B. Participating Sites**  
139
- 140 **I.B.1. There must be a program letter of agreement (PLA) between the**  
141 **program and each participating site providing a required**  
142 **assignment. The PLA must be renewed at least every five years.**  
143  
144 **The PLA should:**  
145
- 146 **I.B.1.a) identify the faculty who will assume both educational and**  
147 **supervisory responsibilities for fellows;**  
148
- 149 **I.B.1.b) specify their responsibilities for teaching, supervision, and**  
150 **formal evaluation of fellows, as specified later in this**  
151 **document;**  
152
- 153 **I.B.1.c) specify the duration and content of the educational**

154 experience; and,  
155  
156 **I.B.1.d) state the policies and procedures that will govern fellow**  
157 **education during the assignment.**  
158  
159 **I.B.2. The program director must submit any additions or deletions of**  
160 **participating sites routinely providing an educational experience,**  
161 **required for all fellows, of one month full time equivalent (FTE) or**  
162 **more through the Accreditation Council for Graduate Medical**  
163 **Education (ACGME) Accreditation Data System (ADS).**  
164  
165 I.B.2.a) ~~Clinical assignments to participating sites must be prior-approved~~  
166 ~~prior to fellows' rotating to the sites, and may be a maximum of~~  
167 ~~must not be more than~~ three months in length. ~~Educational~~  
168 ~~justification for such rotations must be provided to the Review~~  
169 ~~Committee prior to implementation.~~  
170  
171 **II. Program Personnel and Resources**  
172  
173 **II.A. Program Director**  
174  
175 **II.A.1. There must be a single program director with authority and**  
176 **accountability for the operation of the program. The sponsoring**  
177 **institution's GMEC must approve a change in program director.**  
178 **After approval, the program director must submit this change to the**  
179 **ACGME via the ADS.**  
180  
181 II.A.1.a) The length of the program director's appointment must be at least  
182 is two years, i.e., the length of the program plus one year, i.e., two  
183 years.  
184  
185 **II.A.2. Qualifications of the program director must include:**  
186  
187 **II.A.2.a) requisite specialty expertise and documented educational**  
188 **and administrative experience acceptable to the Review**  
189 **Committee;**  
190  
191 **II.A.2.b) current certification in the subspecialty by the American**  
192 **Board of Surgery or subspecialty qualifications that are**  
193 **acceptable to the Review Committee; and,**  
194  
195 **II.A.2.c) current medical licensure and appropriate medical staff**  
196 **appointment.**  
197  
198 II.A.2.c).(1) This must include unrestricted credentials at the primary  
199 clinical site, and  
200  
201 II.A.2.c).(2) The program director should possess licensure to practice  
202 medicine in the state where the primary clinical site is  
203 located.  
204

- 205 II.A.2.d) faculty appointment in good standing at the primary clinical site.  
 206  
 207 **II.A.3. The program director must administer and maintain an educational**  
 208 **environment conducive to educating the fellows in each of the**  
 209 **ACGME competency areas. The program director must:**  
 210  
 211 **II.A.3.a) prepare and submit all information required and requested by**  
 212 **the ACGME;**  
 213  
 214 **II.A.3.b) be familiar with and oversee compliance with ACGME and**  
 215 **Review Committee policies and procedures as outlined in the**  
 216 **ACGME Manual of Policies and Procedures;**  
 217  
 218 **II.A.3.c) obtain review and approval of the sponsoring institution's**  
 219 **GMEC/DIO before submitting to the ACGME information or**  
 220 **requests for the following:**  
 221  
 222 **II.A.3.c).(1) all applications for ACGME accreditation of new**  
 223 **programs;**  
 224  
 225 **II.A.3.c).(2) changes in fellow complement;**  
 226  
 227 **II.A.3.c).(3) major changes in program structure or length of**  
 228 **training;**  
 229  
 230 **II.A.3.c).(4) progress reports requested by the Review Committee;**  
 231  
 232 **II.A.3.c).(5) responses to all proposed adverse actions;**  
 233  
 234 **II.A.3.c).(6) requests for increases or any change to fellow duty**  
 235 **hours;**  
 236  
 237 **II.A.3.c).(7) voluntary withdrawals of ACGME-accredited**  
 238 **programs;**  
 239  
 240 **II.A.3.c).(8) requests for appeal of an adverse action; and,**  
 241  
 242 **II.A.3.c).(9) appeal presentations to a Board of Appeal or the**  
 243 **ACGME.**  
 244  
 245 **II.A.3.d) obtain DIO review and co-signature on all program**  
 246 **information forms, as well as any correspondence or**  
 247 **document submitted to the ACGME that addresses:**  
 248  
 249 **II.A.3.d).(1) program citations, and/or**  
 250  
 251 **II.A.3.d).(2) request for changes in the program that would have**  
 252 **significant impact, including financial, on the program**  
 253 **or institution.**  
 254  
 255 **II.A.3.e) maintain a collegial relationship with ~~the teaching staff~~ faculty**

- 256 members to enhance the educational opportunities for all fellows;  
 257 and,  
 258  
 259 II.A.3.f) direct or co-direct one or more of the critical care units in which  
 260 the clinical aspects of the educational program take place, and  
 261 personally supervise and teach surgery and surgical critical care  
 262 fellows in that unit.  
 263  
 264 II.A.3.g) ~~be the director or co-director of one or more of the critical care~~  
 265 ~~units in which the clinical aspects of the critical care program take~~  
 266 ~~place; and, he or she must be personally involved in clinical~~  
 267 ~~supervision and teaching of general surgery residents and surgical~~  
 268 ~~critical care fellows in that unit;~~  
 269  
 270 II.A.3.h) ~~have administrative responsibility for the surgical critical care~~  
 271 ~~educational program and shall appoint all fellows and teaching~~  
 272 ~~staff to the program and determine their duties;~~  
 273  
 274 II.A.3.i) ~~document to the site visitor that fellows residents in the surgical~~  
 275 ~~critical care program have had direct involvement in the~~  
 276 ~~management of a broad spectrum of critically ill surgical patients.~~  
 277 ~~In addition, each fellow must submit an operative log of the~~  
 278 ~~number and type of operative experiences while in the surgical~~  
 279 ~~critical care residency;~~  
 280  
 281 II.A.3.j) ~~provide a sufficient breadth of patient exposure to ensure that the~~  
 282 ~~program documents an average daily census of at least 10~~  
 283 ~~patients;~~  
 284  
 285 **II.B. Faculty**  
 286  
 287 **II.B.1. There must be a sufficient number of faculty with documented**  
 288 **qualifications to instruct and supervise all fellows.**  
 289  
 290 II.B.1.a) In addition to the program director, at least one surgeon qualified  
 291 certified in surgical critical care must be appointed to the teaching  
 292 staff faculty for every critical care fellow enrolled in the program.  
 293  
 294 **II.B.2. The faculty must devote sufficient time to the educational program**  
 295 **to fulfill their supervisory and teaching responsibilities and**  
 296 **demonstrate a strong interest in the education of fellows.**  
 297  
 298 **II.B.3. The physician faculty must have current certification in the sub**  
 299 **specialty by the American Board of Surgery, or possess**  
 300 **qualifications acceptable to the Review Committee.**  
 301  
 302 II.B.3.a) ~~The surgical critical care faculty to fellow ratio must be at least~~  
 303 ~~4:1.~~  
 304  
 305 **II.B.4. The physician faculty must possess current medical licensure and**  
 306 **appropriate medical staff appointment.**

- 307  
308 II.B.5. Non-surgical physician faculty members must be certified in critical care  
309 in their specialty area or possess alternative qualifications judged to be  
310 acceptable by the Review Committee.  
311  
312 II.B.6. Faculty members must regularly participate in organized clinical  
313 discussions, rounds, journal clubs, and conferences.  
314  
315 II.B.7. Faculty members must establish and maintain an environment of inquiry  
316 and scholarship with an active research component.  
317  
318 II.B.7.a) The program director and some members of the faculty should  
319 also demonstrate scholarship by one or more of the following:  
320  
321 II.B.7.a).(1) peer-reviewed funding;  
322  
323 II.B.7.a).(2) publication of original research or review articles in peer-  
324 reviewed journals, or chapters in textbooks;  
325  
326 II.B.7.a).(3) publication or presentation of case reports or clinical series  
327 at local, regional, or national professional and scientific  
328 society meetings; or,  
329  
330 II.B.7.a).(4) participation in national committees or educational  
331 organizations.  
332  
333 **II.C. Other Program Personnel**  
334  
335 **The institution and the program must jointly ensure the availability of all**  
336 **necessary professional, technical, and clerical personnel for the effective**  
337 **administration of the program.**  
338  
339 II.C.1. Staff members must include specially-trained nurses and technicians ~~who~~  
340 ~~are~~ skilled in critical care instrumentation, respiratory function, and  
341 laboratory medicine.  
342  
343 **II.D. Resources**  
344  
345 **The institution and the program must jointly ensure the availability of**  
346 **adequate resources for fellow education, as defined in the specialty**  
347 **program requirements.**  
348  
349 II.D.1. Resources should include a simulation and skills laboratory.  
350  
351 II.D.2. Resources must include:  
352  
353 II.D.2.a) a critical care unit located in a designated area within the  
354 institution, constructed and designed specifically for the care of  
355 critically-ill patients;  
356  
357 II.D.2.b) a common office space for fellows that includes a sufficient

- 358 number of computers and adequate workspace at the primary  
359 clinical site;  
360  
361 II.D.2.c) online radiographic and laboratory systems at the primary clinical  
362 site and participating sites;  
363  
364 II.D.2.d) software resources for production of presentations, manuscripts,  
365 and portfolios;  
366  
367 II.D.2.e) an average daily census of at least 10 patients in each intensive  
368 care unit to which a fellow is assigned; and,  
369  
370 II.D.2.f) an average daily census for each critical care unit to which fellows  
371 are assigned that ensures a fellow-to-patient ratio of 1:10.  
372  
373 II.D.3. The education ~~may~~must take place in care settings ~~various settings that~~  
374 ~~provide for the care of critically-ill adult and/or pediatric surgical patients.~~  
375 ~~including those with general surgical conditions such as trauma, burns,~~  
376 ~~and surgical oncology; with cardiothoracic, neurosurgical, and high-risk~~  
377 ~~pregnancy conditions; and with organ transplantation~~  
378  
379 **II.E. Medical Information Access**  
380  
381 **Fellows must have ready access to specialty-specific and other appropriate**  
382 **reference material in print or electronic format. Electronic medical literature**  
383 **databases with search capabilities should be available.**  
384  
385 II.E.1. Fellows must have Internet access to full-text journals and electronic  
386 medical reference resources for education and patient care at all  
387 participating sites.  
388  
389 **III. Fellow Appointments**  
390  
391 **III.A. Eligibility Criteria**  
392  
393 **Each fellow must successfully complete an ACGME-accredited specialty**  
394 **program and/or meet other eligibility criteria as specified by the Review**  
395 **Committee. The program must document that each fellow has met the**  
396 **eligibility criteria.**  
397  
398 III.A.1. Prior to appointment in the program, fellows must have completed  
399 Completion of at least three clinical years in an ACGME-accredited  
400 graduate educational program in one of the following specialties: the  
401 disciplines of general anesthesiology, neurological surgery, obstetrics  
402 and gynecology, orthopaedic surgery, otolaryngology, surgery, thoracic  
403 surgery, vascular surgery, or urology. ~~is a prerequisite for admission to~~  
404 ~~the program.~~  
405  
406 **III.B. Number of Fellows**  
407  
408 **The program director may not appoint more fellows than approved by the**

409 **Review Committee, unless otherwise stated in the specialty-specific**  
410 **requirements. The program's educational resources must be adequate to**  
411 **support the number of fellows appointed to the program.**  
412

413 ~~III.B.1. Any increase in fellow complement, permanent or temporary, must be~~  
414 ~~prior-approved by the Review Committee.~~  
415

416 III.C. The presence of other learners, including residents from other specialties,  
417 subspecialty fellows, PhD students, and nurse practitioners, in the program must  
418 not interfere with the appointed fellows' education. The program director must  
419 report the presence of other learners to the DIO and GMEC in accordance with  
420 sponsoring institution guidelines.  
421

#### 422 IV. Educational Program

423  
424 IV.A. The curriculum must contain the following educational components:  
425

426 IV.A.1. **Skills and competencies the fellow will be able to demonstrate at the**  
427 **conclusion of the program. The program must distribute these skills**  
428 **and competencies to fellows and faculty annually, in either written**  
429 **or electronic form. These skills and competencies should be**  
430 **reviewed by the fellow at the start of each rotation;**  
431

432 IV.A.2. **ACGME Competencies**  
433

434 **The program must integrate the following ACGME competencies**  
435 **into the curriculum:**  
436

437 IV.A.2.a) **Patient Care**  
438

439 **Fellows must be able to provide patient care that is**  
440 **compassionate, appropriate, and effective for the treatment of**  
441 **health problems and the promotion of health. Fellows:**  
442

443 IV.A.2.a).(1) must have supervised training that will enable them to gain  
444 demonstrate competence in the performance of the  
445 following critical care skills:  
446

447 IV.A.2.a).(1).(a) respiratory: performance of airway management,  
448 including techniques of intubation, endoscopy, and  
449 tracheostomy, as well as ventilator management;  
450

451 IV.A.2.a).(1).(b) circulatory: performance of invasive and  
452 noninvasive monitoring techniques, and the use of  
453 vasoactive agents and management of hypotension  
454 and shock; application of trans-esophageal and  
455 transthoracic pericardial cardiac ultrasound and  
456 transvenous pacemakers, computations of cardiac  
457 output and of systemic and pulmonary vascular  
458 resistance; monitoring electrocardiograms  
459 dysrhythmia diagnosis and treatment, and the

460		<u>management of cardiac assist devices;</u>
461		
462	IV.A.2.a).(1).(c)	<u>neurological: performance of management of</u>
463		<u>intracranial pressure and acute neurologic</u>
464		<u>emergencies, including application of the use of</u>
465		<u>intracranial pressure monitoring techniques and</u>
466		<u>electroencephalography to evaluate cerebral</u>
467		<u>function; application of hypothermia in the</u>
468		<u>management of cerebral trauma;</u>
469		
470	IV.A.2.a).(1).(d)	<u>renal: the performance of the evaluation of renal</u>
471		<u>function; use of renal replacement therapies;</u>
472		<u>peritoneal dialysis and hemofiltration; management</u>
473		<u>of hemodialysis, and management of electrolyte</u>
474		<u>disorders and acid-base disturbances; and</u>
475		<u>including applying application of knowledge of the</u>
476		<u>indications for and complications of hemodialysis;</u>
477		
478	IV.A.2.a).(1).(e)	<u>gastrointestinal: performance of utilization of</u>
479		<u>gastrointestinal intubation and endoscopic</u>
480		<u>techniques in the management of the critically-ill</u>
481		<u>patient; application of enteral feedings; and</u>
482		<u>management of stomas, fistulas, and percutaneous</u>
483		<u>catheter devices;</u>
484		
485	IV.A.2.a).(1).(f)	<u>hematologic: performance of application of</u>
486		<u>autotransfusion; assessment of coagulation status,</u>
487		<u>and appropriate use of component therapy;</u>
488		
489	IV.A.2.a).(1).(g)	<u>infectious disease: performance of classification of</u>
490		<u>infections and application of isolation techniques,</u>
491		<u>pharmacokinetics, drug interactions, and</u>
492		<u>management of antibiotic therapy during organ</u>
493		<u>failure; nosocomial infections; and management of</u>
494		<u>sepsis and septic shock indications for applications</u>
495		<u>of hyperbaric oxygen therapy;</u>
496		
497	IV.A.2.a).(1).(h)	<u>endocrine: performance of the diagnosis and</u>
498		<u>management of acute endocrine disorders,</u>
499		<u>including those of the pancreas, thyroid, adrenals,</u>
500		<u>and pituitary;</u>
501		
502	IV.A.2.a).(1).(i)	<u>nutritional: application performance of the use of</u>
503		<u>parenteral and enteral nutrition, and monitoring and</u>
504		<u>assessing metabolism and nutrition; and,</u>
505		
506	IV.A.2.a).(1).(j)	<u>monitoring/bioengineering: performance of the use</u>
507		<u>and calibration of transducers and other medical</u>
508		<u>devices, amplifiers, and recorders;</u>
509		
510	IV.A.2.a).(2)	<u>must have supervised training that will enable them to gain</u>

511		<u>demonstrate competence in the application of the following</u>
512		<u>critical care skills:</u>
513		
514	IV.A.2.a).(2).(a)	<u>circulatory: transvenous pacemakers; <del>computations</del></u>
515		<u><del>of cardiac output and of systemic and pulmonary</del></u>
516		<u><del>vascular resistance; monitoring electrocardiograms</del></u>
517		<u><del>dysrhythmia diagnosis and treatment, and the</del></u>
518		<u><del>management of cardiac assist devices; and use of</del></u>
519		<u><del>vasoactive agents and the management of</del></u>
520		<u><del>hypotension and shock;</del></u>
521		
522	IV.A.2.a).(2).(b)	<u>neurological: the use of intracranial pressure</u>
523		<u>monitoring techniques and <del>of the</del></u>
524		<u><del>electroencephalogram</del> electroencephalography to</u>
525		<u><del>evaluate cerebral function; application of</del></u>
526		<u><del>hypothermia in the management of cerebral</del></u>
527		<u><del>trauma;</del></u>
528		
529	IV.A.2.a).(2).(c)	<u>renal: knowledge of the indications for and</u>
530		<u>complications of hemodialysis, and management of</u>
531		<u>electrolyte disorders and acid-base disturbances;</u>
532		<u>and,</u>
533		
534	IV.A.2.a).(2).(d)	<u>miscellaneous: performance of the use of special</u>
535		<u>beds for specific injuries; and employment of</u>
536		<u><del>pneumatic antishock garments, skeletal traction</del></u>
537		<u><del>and fixation devices.</del></u>
538		
539	<b>IV.A.2.b)</b>	<b>Medical Knowledge</b>
540		
541		<b>Fellows must demonstrate knowledge of established and</b>
542		<b>evolving biomedical, clinical, epidemiological and social-</b>
543		<b>behavioral sciences, as well as the application of this</b>
544		<b>knowledge to patient care. Fellows:</b>
545		
546	IV.A.2.b).(1)	must <u>demonstrate</u> <del>acquire</del> advanced knowledge of the
547		following aspects of critical care, particularly as they relate
548		to the management of patients with hemodynamic
549		instability, multiple system organ failure, and complex
550		coexisting medical problems:
551		
552	IV.A.2.b).(1).(a)	cardiorespiratory resuscitation;
553		
554	IV.A.2.b).(1).(b)	physiology, pathophysiology, diagnosis, and
555		therapy of disorders of the cardiovascular,
556		respiratory, gastrointestinal, genitourinary,
557		neurological, endocrine, musculoskeletal, and
558		immune systems, as well as of infectious diseases;
559		
560	IV.A.2.b).(1).(c)	metabolic, nutritional, and endocrine effects of
561		critical illness;

562		
563	IV.A.2.b).(1).(d)	hematologic and coagulation disorders;
564		
565	IV.A.2.b).(1).(e)	critical obstetric and gynecologic disorders;
566		
567	IV.A.2.b).(1).(f)	trauma, thermal, electrical, and radiation injuries;
568		
569	IV.A.2.b).(1).(g)	inhalation and immersion injuries;
570		
571	IV.A.2.b).(1).(h)	monitoring and medical instrumentation;
572		
573	IV.A.2.b).(1).(i)	critical pediatric surgical conditions;
574		
575	IV.A.2.b).(1).(j)	pharmacokinetics and dynamics of drug
576		metabolism and excretion in critical illness;
577		
578	IV.A.2.b).(1).(k)	ethical and legal aspects of surgical critical care;
579		
580	IV.A.2.b).(1).(l)	principles and techniques of administration and
581		management; <u>and</u> ,
582		
583	IV.A.2.b).(1).(m)	biostatistics and experimental design.
584		
585	IV.A.2.b).(2)	<del>must acquire an advanced body of knowledge and level of</del>
586		<del>skill in the management of critically ill surgical patients in</del>
587		<del>order to assume a leadership role in teaching and in</del>
588		<del>research in surgical critical care. This advanced body of</del>
589		<del>knowledge and level of skill must include the mastery of:</del>
590		
591	IV.A.2.b).(2).(a)	<del>the use of advanced technology and</del>
592		<del>instrumentation to monitor the physiologic status of</del>
593		<del>children or adults of both sexes, including those in</del>
594		<del>the neonatal, pediatric, child-bearing, or advanced</del>
595		<del>years;</del>
596		
597	IV.A.2.b).(2).(b)	<del>organizational and administrative aspects of a</del>
598		<del>critical care unit;</del>
599		
600	IV.A.2.b).(2).(c)	<del>ethical, economic, and legal issues as they pertain</del>
601		<del>to critical care.</del>
602		
603	<b>IV.A.2.c)</b>	<b>Practice-based Learning and Improvement</b>
604		
605		<b>Fellows are expected to develop skills and habits to be able</b>
606		<b>to meet the following goals:</b>
607		
608	<b>IV.A.2.c).(1)</b>	<b>systematically analyze practice using quality</b>
609		<b>improvement methods, and implement changes with</b>
610		<b>the goal of practice improvement;</b>
611		
612	<b>IV.A.2.c).(2)</b>	<b>locate, appraise, and assimilate evidence from</b>

613		<b>scientific studies related to their patients' health</b>
614		<b>problems.</b>
615		
616	IV.A.2.c).(3)	<del>undertake investigations into the various areas of surgical</del>
617		<del>critical care, such as new instrumentation, identification of</del>
618		<del>important physiologic parameters, evaluation of</del>
619		<del>pharmacologic agents in critically ill patients, or health</del>
620		<del>outcomes and/or health policy issues related to surgical</del>
621		<del>critical care.</del>
622		
623	<b>IV.A.2.d)</b>	<b>Interpersonal and Communication Skills</b>
624		
625		<b>Fellows must demonstrate interpersonal and communication</b>
626		<b>skills that result in the effective exchange of information and</b>
627		<b>collaboration with patients, their families, and health</b>
628		<b>professionals.</b>
629		
630	IV.A.2.d).(1)	<del>Fellows completing a surgical critical care residency</del>
631		<del>program will be expected to <u>must demonstrate effective</u></del>
632		<del><u>skills in teaching</u> the specialty of surgical critical care.</del>
633		
634	<b>IV.A.2.e)</b>	<b>Professionalism</b>
635		
636		<b>Fellows must demonstrate a commitment to carrying out</b>
637		<b>professional responsibilities and an adherence to ethical</b>
638		<b>principles.</b>
639		
640	<b>IV.A.2.f)</b>	<b>Systems-based Practice</b>
641		
642		<b>Fellows must demonstrate an awareness of and</b>
643		<b>responsiveness to the larger context and system of health</b>
644		<b>care, as well as the ability to call effectively on other</b>
645		<b>resources in the system to provide optimal health care.</b>
646		
647	IV.A.2.f).(1)	<del>Fellows completing a surgical critical care residency</del>
648		<del>program will be expected to <u>must be able to</u> administer a</del>
649		<del>surgical critical care unit and appoint, educate, and</del>
650		<del>supervise specialized personnel; establish policy and</del>
651		<del>procedures for the unit; and coordinate the activities of the</del>
652		<del>unit with other administrative units within the hospital.</del>
653		
654	IV.A.3.	<u>Curriculum Organization and Fellow Experiences</u>
655		
656	IV.A.3.a)	<u>All</u> 12 months must be devoted to advanced educational and
657		clinical activities related to the care of critically-ill patients and to
658		the administration of critical care units.
659		
660	IV.A.3.a).(1)	<u>At least eight months must be in a surgical intensive care</u>
661		<u>unit.</u>
662		
663	IV.A.3.a).(1).(a)	<u>At least five of the eight months should be in a unit</u>

- 664 in which a surgeon is director or co-director.
- 665
- 666 IV.A.3.a).(1).(b) The surgical intensive care unit must be largely
- 667 dedicated to the care of one or more of the
- 668 following surgical patients: trauma, burn,
- 669 neurosurgical, pediatric surgical, cardiothoracic,
- 670 transplant, and adult surgical.
- 671
- 672 IV.A.3.a).(2) No more than two months should be in non-surgical
- 673 intensive care units, such as medical, cardiac, or pediatric
- 674 units.
- 675
- 676 IV.A.3.a).(3) No more than two months should be in elective rotations in
- 677 areas relevant to critical care, such as trauma or acute
- 678 care surgery.
- 679
- 680 IV.A.3.a).(3).(a) Elective clinical rotations done outside of the critical
- 681 care unit should involve the care of patients with
- 682 acute surgical diseases such as those related to
- 683 injury or emergent surgical conditions.
- 684
- 685 IV.A.3.b) The core curriculum must include a regularly-scheduled didactic
- 686 program based on the core knowledge content and areas defined
- 687 as a fellow's outcomes in the specialty.
- 688
- 689 IV.A.3.c) Participation in direct operative care of critically-ill patients in the
- 690 operating room during critical care rotations should not be so great
- 691 as to interfere with the primary educational purpose of the critical
- 692 care rotation.
- 693
- 694 IV.A.3.d) document to the site visitor that fellows residents in the surgical
- 695 critical care program have had direct involvement in the
- 696 management of a broad spectrum of critically ill surgical patients.
- 697 Fellows must keep two written records of their experience: a
- 698 summary record documenting the numbers and types of critical
- 699 care patients; and an operative log of numbers and types of
- 700 operative experiences, including bedside procedures.
- 701
- 702 IV.A.3.e) A chief resident in surgery and a fellow in surgical critical care
- 703 must not have primary responsibility for the same patient.
- 704
- 705 **IV.B. Fellows' Scholarly Activities**
- 706
- 707 **V. Evaluation**
- 708
- 709 **V.A. Fellow Evaluation**
- 710
- 711 **V.A.1. Formative Evaluation**
- 712
- 713 **V.A.1.a) The faculty must evaluate fellow performance in a timely**
- 714 **manner.**

715		
716	<b>V.A.1.b)</b>	<b>The program must:</b>
717		
718	<b>V.A.1.b).(1)</b>	<b>provide objective assessments of competence in</b>
719		<b>patient care, medical knowledge, practice-based</b>
720		<b>learning and improvement, interpersonal and</b>
721		<b>communication skills, professionalism, and systems-</b>
722		<b>based practice;</b>
723		
724	<b>V.A.1.b).(2)</b>	<b>use multiple evaluators (e.g., faculty, peers, patients,</b>
725		<b>self, and other professional staff); and,</b>
726		
727	<b>V.A.1.b).(3)</b>	<b>provide each fellow with documented semiannual</b>
728		<b>evaluation of performance with feedback.</b>
729		
730	<b>V.A.1.c)</b>	<b>The evaluations of fellow performance must be accessible for</b>
731		<b>review by the fellow, in accordance with institutional policy.</b>
732		
733	<b>V.A.1.d)</b>	<u><b>Semiannual assessment must include a review of case volume,</b></u>
734		<u><b>breadth, and complexity, and must ensure that fellows are</b></u>
735		<u><b>maintaining the required written records.</b></u>
736		
737	<b>V.A.2.</b>	<b>Summative Evaluation</b>
738		
739		<b>The program director must provide a summative evaluation for each</b>
740		<b>fellow upon completion of the program. This evaluation must</b>
741		<b>become part of the fellow’s permanent record maintained by the</b>
742		<b>institution, and must be accessible for review by the fellow in</b>
743		<b>accordance with institutional policy. This evaluation must:</b>
744		
745	<b>V.A.2.a)</b>	<b>document the fellow’s performance during their education,</b>
746		<b>and</b>
747		
748	<b>V.A.2.b)</b>	<b>verify that the fellow has demonstrated sufficient competence</b>
749		<b>to enter practice without direct supervision.</b>
750		
751	<b>V.B.</b>	<b>Faculty Evaluation</b>
752		
753	<b>V.B.1.</b>	<b>At least annually, the program must evaluate faculty performance as</b>
754		<b>it relates to the educational program.</b>
755		
756	<b>V.B.2.</b>	<b>These evaluations should include a review of the faculty’s clinical</b>
757		<b>teaching abilities, commitment to the educational program, clinical</b>
758		<b>knowledge, professionalism, and scholarly activities.</b>
759		
760	<b>V.C.</b>	<b>Program Evaluation and Improvement</b>
761		
762	<b>V.C.1.</b>	<b>The program must document formal, systematic evaluation of the</b>
763		<b>curriculum at least annually. The program must monitor and track</b>
764		<b>each of the following areas:</b>
765		

- 766 V.C.1.a) fellow performance, and  
767
- 768 V.C.1.b) faculty development.  
769
- 770 V.C.2. If deficiencies are found, the program should prepare a written plan  
771 of action to document initiatives to improve performance in the  
772 areas listed in section V.C.1. The action plan should be reviewed  
773 and approved by the teaching faculty and documented in meeting  
774 minutes.  
775
- 776 V.C.3. 65% of a program's graduates from the preceding five years taking the  
777 American Board of Surgery certifying examination for surgical critical care  
778 for the first time must pass.  
779
- 780 VI. Fellow Duty Hours in the Learning and Working Environment  
781
- 782 VI.A. Professionalism, Personal Responsibility, and Patient Safety  
783
- 784 VI.A.1. Programs and sponsoring institutions must educate fellows and  
785 faculty members concerning the professional responsibilities of  
786 physicians to appear for duty appropriately rested and fit to provide  
787 the services required by their patients.  
788
- 789 VI.A.2. The program must be committed to and responsible for promoting  
790 patient safety and fellow well-being in a supportive educational  
791 environment.  
792
- 793 VI.A.3. The program director must ensure that fellows are integrated and  
794 actively participate in interdisciplinary clinical quality improvement  
795 and patient safety programs.  
796
- 797 VI.A.4. The learning objectives of the program must:  
798
- 799 VI.A.4.a) be accomplished through an appropriate blend of supervised  
800 patient care responsibilities, clinical teaching, and didactic  
801 educational events; and,  
802
- 803 VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill  
804 non-physician service obligations.  
805
- 806 VI.A.5. The program director and sponsoring institution must ensure a  
807 culture of professionalism that supports patient safety and personal  
808 responsibility. Fellows and faculty members must demonstrate an  
809 understanding and acceptance of their personal role in the  
810 following:  
811
- 812 VI.A.5.a) assurance of the safety and welfare of patients entrusted to  
813 their care;  
814
- 815 VI.A.5.b) provision of patient- and family-centered care;  
816

- 817 VI.A.5.c) assurance of their fitness for duty;  
818
- 819 VI.A.5.d) management of their time before, during, and after clinical  
820 assignments;  
821
- 822 VI.A.5.e) recognition of impairment, including illness and fatigue, in  
823 themselves and in their peers;  
824
- 825 VI.A.5.f) attention to lifelong learning;  
826
- 827 VI.A.5.g) the monitoring of their patient care performance improvement  
828 indicators; and,  
829
- 830 VI.A.5.h) honest and accurate reporting of duty hours, patient  
831 outcomes, and clinical experience data.  
832
- 833 VI.A.6. All fellows and faculty members must demonstrate responsiveness  
834 to patient needs that supersedes self-interest. Physicians must  
835 recognize that under certain circumstances, the best interests of the  
836 patient may be served by transitioning that patient's care to another  
837 qualified and rested provider.  
838
- 839 VI.B. Transitions of Care  
840
- 841 VI.B.1. Programs must design clinical assignments to minimize the number  
842 of transitions in patient care.  
843
- 844 VI.B.2. Sponsoring institutions and programs must ensure and monitor  
845 effective, structured hand-over processes to facilitate both  
846 continuity of care and patient safety.  
847
- 848 VI.B.3. Programs must ensure that fellows are competent in communicating  
849 with team members in the hand-over process.  
850
- 851 VI.B.4. The sponsoring institution must ensure the availability of schedules  
852 that inform all members of the health care team of attending  
853 physicians and fellows currently responsible for each patient's care.  
854
- 855 VI.C. Alertness Management/Fatigue Mitigation  
856
- 857 VI.C.1. The program must:  
858
- 859 VI.C.1.a) educate all faculty members and fellows to recognize the  
860 signs of fatigue and sleep deprivation;  
861
- 862 VI.C.1.b) educate all faculty members and fellows in alertness  
863 management and fatigue mitigation processes; and,  
864
- 865 VI.C.1.c) adopt fatigue mitigation processes to manage the potential  
866 negative effects of fatigue on patient care and learning, such  
867 as naps or back-up call schedules.

- 868  
869 **VI.C.2.** Each program must have a process to ensure continuity of patient  
870 care in the event that a fellow may be unable to perform his/her  
871 patient care duties.  
872
- 873 **VI.C.3.** The sponsoring institution must provide adequate sleep facilities  
874 and/or safe transportation options for fellows who may be too  
875 fatigued to safely return home.  
876
- 877 **VI.D. Supervision of Fellows**  
878
- 879 **VI.D.1.** In the clinical learning environment, each patient must have an  
880 identifiable, appropriately-credentialed and privileged attending  
881 physician (or licensed independent practitioner as approved by each  
882 Review Committee) who is ultimately responsible for that patient's  
883 care.  
884
- 885 **VI.D.1.a)** This information should be available to fellows, faculty  
886 members, and patients.  
887
- 888 **VI.D.1.b)** Fellows and faculty members should inform patients of their  
889 respective roles in each patient's care.  
890
- 891 **VI.D.2.** The program must demonstrate that the appropriate level of  
892 supervision is in place for all fellows who care for patients.  
893  
894 **Supervision may be exercised through a variety of methods. Some**  
895 **activities require the physical presence of the supervising faculty**  
896 **member. For many aspects of patient care, the supervising**  
897 **physician may be a more advanced fellow. Other portions of care**  
898 **provided by the fellow can be adequately supervised by the**  
899 **immediate availability of the supervising faculty member or fellow**  
900 **physician, either in the institution, or by means of telephonic and/or**  
901 **electronic modalities. In some circumstances, supervision may**  
902 **include post-hoc review of fellow-delivered care with feedback as to**  
903 **the appropriateness of that care.**  
904
- 905 **VI.D.3. Levels of Supervision**  
906  
907 **To ensure oversight of fellow supervision and graded authority and**  
908 **responsibility, the program must use the following classification of**  
909 **supervision:**  
910
- 911 **VI.D.3.a)** **Direct Supervision – the supervising physician is physically**  
912 **present with the fellow and patient.**  
913
- 914 **VI.D.3.b)** **Indirect Supervision:**  
915
- 916 **VI.D.3.b).(1)** **with direct supervision immediately available – the**  
917 **supervising physician is physically within the hospital**  
918 **or other site of patient care, and is immediately**

919		available to provide Direct Supervision.
920		
921	<b>VI.D.3.b).(2)</b>	<b>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.</b>
922		
923		
924		
925		
926		
927		
928	<b>VI.D.3.c)</b>	<b>Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.</b>
929		
930		
931		
932	<b>VI.D.4.</b>	<b>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.</b>
933		
934		
935		
936		
937	<b>VI.D.4.a)</b>	<b>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.</b>
938		
939		
940		
941	<b>VI.D.4.b)</b>	<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.</b>
942		
943		
944		
945	<b>VI.D.4.c)</b>	<b>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.</b>
946		
947		
948		
949		
950	<b>VI.D.5.</b>	<b>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.</b>
951		
952		
953		
954		
955	<b>VI.D.5.a)</b>	<b>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.</b>
956		
957		
958		
959	<b>VI.D.6.</b>	<b>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.</b>
960		
961		
962		
963		
964	<b>VI.E.</b>	<b>Clinical Responsibilities</b>
965		
966		<b>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.</b>
967		
968		
969		

- 970 VI.E.1. The workload associated with optimal clinical care of surgical patients is a  
971 continuum from the moment of admission to the point of discharge.  
972
- 973 VI.E.2. During the residency education process, surgical teams should be made  
974 up of attending surgeons, residents at various PG levels, medical  
975 students (when appropriate), and other health care providers.  
976
- 977 VI.A.1. The work of the caregiver team should be assigned to team members  
978 based on each member's level of education, experience, and  
979 competence.  
980
- 981 VI.A.2. As fellows progress through levels of increasing competence and  
982 responsibility, it is expected that work assignments will keep pace with  
983 their advancement.  
984
- 985 **VI.F. Teamwork**  
986  
987 **Fellows must care for patients in an environment that maximizes effective**  
988 **communication. This must include the opportunity to work as a member of**  
989 **effective interprofessional teams that are appropriate to the delivery of care**  
990 **in the specialty.**  
991
- 992 VI.F.1. Effective surgical practices entail the involvement of members with a mix  
993 of complementary skills and attributes (physicians, nurses, and other  
994 staff). Success requires both an unwavering mutual respect for those  
995 skills and contributions, and a shared commitment to the process of  
996 patient care.  
997
- 998 VI.F.2. Fellows must collaborate with fellow surgical residents, and especially  
999 with faculty, other physicians outside of their specialty, and non-traditional  
1000 health care providers, to best formulate treatment plans for an  
1001 increasingly diverse patient population.  
1002
- 1003 VI.F.3. Fellows must assume personal responsibility to complete all tasks to  
1004 which they are assigned (or which they voluntarily assume) in a timely  
1005 fashion. These tasks must be completed in the hours assigned, or, if that  
1006 is not possible, fellows must learn and utilize the established methods for  
1007 handing off remaining tasks to another member of the fellow team so that  
1008 patient care is not compromised.  
1009
- 1010 VI.F.4. Lines of authority should be defined by programs, and all fellows must  
1011 have a working knowledge of these expected reporting relationships to  
1012 maximize quality care and patient safety.  
1013
- 1014 **VI.G. Fellow Duty Hours**  
1015
- 1016 **VI.G.1. Maximum Hours of Work per Week**  
1017  
1018 **Duty hours must be limited to 80 hours per week, averaged over a**  
1019 **four-week period, inclusive of all in-house call activities and all**  
1020 **moonlighting.**

1021		
1022	<b>VI.G.1.a)</b>	<b>Duty Hour Exceptions</b>
1023		
1024		<b>A Review Committee may grant exceptions for up to 10% or a</b>
1025		<b>maximum of 88 hours to individual programs based on a</b>
1026		<b>sound educational rationale.</b>
1027		
1028		The Review Committee for General Surgery will not consider
1029		requests for exceptions to the 80-hour limit to the fellows' work
1030		week.
1031		
1032	<b>VI.G.1.a).(1)</b>	<b>In preparing a request for an exception the program</b>
1033		<b>director must follow the duty hour exception policy</b>
1034		<b>from the ACGME Manual on Policies and Procedures.</b>
1035		
1036	<b>VI.G.1.a).(2)</b>	<b>Prior to submitting the request to the Review</b>
1037		<b>Committee, the program director must obtain approval</b>
1038		<b>of the institution's GMEC and DIO.</b>
1039		
1040	<b>VI.G.2.</b>	<b>Moonlighting</b>
1041		
1042	<b>VI.G.2.a)</b>	<b>Moonlighting must not interfere with the ability of the fellow</b>
1043		<b>to achieve the goals and objectives of the educational</b>
1044		<b>program.</b>
1045		
1046	<b>VI.G.2.b)</b>	<b>Time spent by fellows in Internal and External Moonlighting</b>
1047		<b>(as defined in the ACGME Glossary of Terms) must be</b>
1048		<b>counted towards the 80-hour Maximum Weekly Hour Limit.</b>
1049		
1050	<b>VI.G.3.</b>	<b>Mandatory Time Free of Duty</b>
1051		
1052		<b>Fellows must be scheduled for a minimum of one day free of duty</b>
1053		<b>every week (when averaged over four weeks). At-home call cannot</b>
1054		<b>be assigned on these free days.</b>
1055		
1056	<b>VI.G.4.</b>	<b>Maximum Duty Period Length</b>
1057		
1058		<b>Duty periods of fellows may be scheduled to a maximum of 24 hours</b>
1059		<b>of continuous duty in the hospital. Programs must encourage</b>
1060		<b>fellows to use alertness management strategies in the context of</b>
1061		<b>patient care responsibilities. Strategic napping, especially after 16</b>
1062		<b>hours of continuous duty and between the hours of 10:00 p.m. and</b>
1063		<b>8:00 a.m., is strongly suggested.</b>
1064		
1065	<b>VI.G.4.a)</b>	<b>It is essential for patient safety and fellow education that</b>
1066		<b>effective transitions in care occur. Fellows may be allowed to</b>
1067		<b>remain on-site in order to accomplish these tasks; however,</b>
1068		<b>this period of time must be no longer than an additional four</b>
1069		<b>hours.</b>
1070		
1071	<b>VI.G.4.b)</b>	<b>Fellows must not be assigned additional clinical</b>

1072		responsibilities after 24 hours of continuous in-house duty.
1073		
1074	<b>VI.G.4.c)</b>	<b>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.</b>
1075		
1076		
1077		
1078		
1079		
1080		
1081		
1082	<b>VI.G.4.c).(1)</b>	<b>Under those circumstances, the fellow must:</b>
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1084	<b>VI.G.4.c).(1).(a)</b>	<b>appropriately hand over the care of all other patients to the team responsible for their continuing care; and,</b>
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1088	<b>VI.G.4.c).(1).(b)</b>	<b>document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.</b>
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1093	<b>VI.G.4.c).(2)</b>	<b>The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.</b>
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1097	<b>VI.G.5.</b>	<b>Minimum Time Off between Scheduled Duty Periods</b>
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1099	<b>VI.G.5.a)</b>	<b>Fellows must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.</b>
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1103		Surgical critical care fellows are considered to be in the final years of education.
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1106	<b>VI.G.5.a).(1)</b>	<b>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.</b>
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1115	<b>VI.G.5.a).(1).(a)</b>	<b>Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by fellows must be monitored by the program director.</b>
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1120	<b>VI.G.5.a).(1).(b)</b>	<b>The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient</b>
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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**

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

VI.G.6.a) Any rotation that requires fellows to work nights in succession, is considered a night float rotation, and the total time on nights is counted toward the maximum allowable time for each fellow resident over the five-year residency

VI.G.6.b) Night float rotations must not exceed two months in succession, or three months in succession for rotations with night shifts alternating with day shifts.

VI.G.6.c) There can be no more than four months of night float per year.

VI.G.6.d) There must be at least two months between each night float rotation.

**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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