



**Accreditation Council for
Graduate Medical Education**

**ACGME Program Requirements for
Graduate Medical Education
in Pediatric Emergency Medicine**

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Common Program Requirements are in Bold

Introduction

Int.A. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the 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 fellow physician to assume personal responsibility for the care of individual patients. For the 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 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 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.

The goal of a residency program in pediatric emergency medicine is to produce physicians who are clinically in the management of the acutely ill or injured child in the setting of an emergency department that is approved as a 911-receiving facility or its equivalent and that has an emergency medical services system.

Fellows seeking certification in the subspecialty of pediatric emergency medicine should consult their primary specialty board, i.e., the American Board of Pediatrics (ABP) or the American Board of Emergency Medicine (ABEM), regarding the criteria for certification eligibility in this subspecialty.

Int.B. Duration and Scope of Educational Experience

Int.B.1. All fellows must receive at least two years of training. Pediatrics graduates must be provided with a third year of training to meet the ABP requirements for scholarly activity. ^{(Core)*}

Int.B.1.a) Emergency medicine programs must provide a third year of training so that pediatrics graduates may complete the ABP requirements for scholarly activity. ^{(Core)*}

Int.B.1.b) Pediatrics sponsored programs that wish to accept emergency

medicine trained graduates must provide a two-year residency curriculum. ^(Core)

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. ^(Core)

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. ^(Core)

I.A.1. The same institution that sponsors the related core Emergency Medicine program should sponsor the subspecialty program. ^(Core)

I.A.2. A program in pediatric emergency medicine must be administered by, and be an integral part of, an Accreditation Council for Graduate Medical Education (ACGME)-accredited program in either emergency medicine or pediatrics. The program must also be affiliated with an ACGME-accredited residency program in the reciprocal discipline (i.e., pediatrics for those programs administered by an emergency medicine program; emergency medicine for those administered by pediatrics). ^(Core)

I.A.3. Interaction among the pediatric emergency medicine fellows, faculty, and residents in the core residency program is required. Lines of responsibility for the fellows must be clearly defined. The presence of a subspecialty program should not adversely affect the education of the Emergency Medicine residents. ^(Core)

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. ^(Detail)

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for fellows; ^(Detail)

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document; ^(Detail)

I.B.1.c) specify the duration and content of the educational experience; and, ^(Detail)

- I.B.1.d)** state the policies and procedures that will govern fellow education during the assignment. ^(Detail)
- 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). ^(Core)
- I.B.3.** An accredited program may span one or more sites. Use of a participating site that provides four or more months of the inpatient and/or outpatient training requires approval by the Review Committee. ^(Detail)

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. ^(Core)
- II.A.1.a)** The program director must submit this change to the ACGME via the ADS. ^(Core)
- II.A.2.** The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability. ^(Detail)
- II.A.3.** Qualifications of the program director must include:
- II.A.3.a)** requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee; ^(Core)
- II.A.3.b)** current certification in the specialty by the American Board of Medical Specialties in Pediatric Emergency Medicine, or specialty qualifications that are acceptable to the Review Committee; ^(Core)
- II.A.3.c)** current medical licensure and appropriate medical staff appointment; ^(Core)
- II.A.3.d)** three years' experience as a clinician, teacher, and administrator in pediatric emergency medicine; and, ^(Core)
- II.A.3.e)** a record of ongoing involvement in scholarly activities, including peer review publications, and mentoring (i.e., guiding fellows in the acquisition of competence in the clinical, teaching, research and advocacy skills pertinent to the discipline). ^(Core)
- II.A.4.** The program director must administer and maintain an educational

environment conducive to educating the fellows in each of the ACGME competency areas. ^(Core)

The program director must:

- II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;** ^(Core)
 - II.A.4.b) approve a local director at each participating site who is accountable for fellow education;** ^(Core)
 - II.A.4.c) approve the selection of program faculty as appropriate;** ^(Core)
 - II.A.4.d) evaluate program faculty;** ^(Core)
 - II.A.4.e) approve the continued participation of program faculty based on evaluation;** ^(Core)
 - II.A.4.f) monitor fellow supervision at all participating sites;** ^(Core)
 - II.A.4.g) prepare and submit all information required and requested by the ACGME,** ^(Core)
 - II.A.4.g).(1) This includes but is not limited to the program information forms and annual program fellow updates to the ADS, and ensure that the information submitted is accurate and complete.** ^(Core)
 - II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;** ^(Detail)
 - II.A.4.i) provide verification of residency education for all fellows, including those who leave the program prior to completion;** ^(Detail)
 - II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for fellow duty hours and the working environment, including moonlighting,** ^(Core)
- and, to that end, must:**
- II.A.4.j).(1) distribute these policies and procedures to the fellows and faculty;** ^(Detail)
 - II.A.4.j).(2) monitor fellow duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;** ^(Core)
 - II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,** ^(Detail)

- II.A.4.j).(4)** if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue. ^(Detail)
- II.A.4.k)** monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged; ^(Detail)
- II.A.4.l)** comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of fellows, disciplinary action, and supervision of fellows; ^(Detail)
- II.A.4.m)** be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures; ^(Detail)
- II.A.4.n)** obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including: ^(Core)
- II.A.4.n).(1)** all applications for ACGME accreditation of new programs; ^(Detail)
 - II.A.4.n).(2)** changes in fellow complement; ^(Detail)
 - II.A.4.n).(3)** major changes in program structure or length of training; ^(Detail)
 - II.A.4.n).(4)** progress reports requested by the Review Committee; ^(Detail)
 - II.A.4.n).(5)** responses to all proposed adverse actions; ^(Detail)
 - II.A.4.n).(6)** requests for increases or any change to fellow duty hours; ^(Detail)
 - II.A.4.n).(7)** voluntary withdrawals of ACGME-accredited programs; ^(Detail)
 - II.A.4.n).(8)** requests for appeal of an adverse action; ^(Detail)
 - II.A.4.n).(9)** appeal presentations to a Board of Appeal or the ACGME; and, ^(Detail)
 - II.A.4.n).(10)** proposals to ACGME for approval of innovative educational approaches. ^(Detail)
- II.A.4.o)** obtain DIO review and co-signature on all program information forms, as well as any correspondence or

document submitted to the ACGME that addresses: ^(Detail)

- II.A.4.o).(1) **program citations, and/or,** ^(Detail)
- II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.** ^(Detail)
- II.A.4.p) be a member of the core teaching faculty; ^(Core)
- II.A.4.p).(1) Core and subspecialty program directors should work together to achieve the ACGME Common Program Requirements and the fellowship competencies. Close coordination among core and subspecialty program directors will foster consistent expectations for fellows with regard to their achievement of competencies, and for faculty with regard to evaluation processes. ^(Core)
- II.A.4.q) ensure that the fellows are mentored in their development of clinical, educational, and administrative skills; ^(Detail)
- II.A.4.r) monitor and document the procedural skills of the fellows; and, ^(Detail)
- II.A.4.s) ensure documentation of meetings that describe ongoing interaction among subspecialty and core program directors. ^(Detail)
- II.A.4.s).(1) These must take place at least annually and more frequently as needed. These meetings should address a departmental approach to common educational issues and concerns (e.g., core curriculum, competencies, and evaluation). ^(Detail)

II.B. Faculty

II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows at that location. ^(Core)

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of fellows, and ^(Core)

II.B.1.b) administer and maintain an educational environment conducive to educating fellows in each of the ACGME competency areas. ^(Core)

II.B.2. The physician faculty must have current certification in the specialty

by the American Board of Medical Specialties in Pediatric Emergency Medicine, or possess qualifications judged acceptable to the Review Committee. ^(Core)

- II.B.2.a) Two faculty members must be certified in pediatric emergency medicine or possess qualifications acceptable to the residency Review Committee. ^(Core)
- II.B.2.b) The remaining faculty members must be certified in pediatrics, emergency medicine, pediatric emergency medicine or possess qualifications acceptable to the Review Committee. ^(Core)
- II.B.2.c) Fellows must have ready access to appropriate teaching and consultant faculty in the full range of Emergency Medicine subspecialties and in other appropriate related disciplines. ^(Core)
- II.B.2.c).(1) Other related disciplines should include medical genetics, child neurology, child and adolescent psychiatry, as well as surgery and surgical subspecialties, as appropriate to Pediatric Emergency Medicine. ^(Detail)
- II.B.3. **The physician faculty must possess current medical licensure and appropriate medical staff appointment.** ^(Core)
- II.B.4. **The non-physician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.** ^(Core)
- II.B.5. **The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.** ^(Core)
- II.B.5.a) **The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.** ^(Detail)
- II.B.5.b) **Some members of the faculty should also demonstrate scholarship by one or more of the following:**
- II.B.5.b).(1) **peer-reviewed funding;** ^(Detail)
- II.B.5.b).(2) **publication of original research or review articles in peer reviewed journals, or chapters in textbooks;** ^(Detail)
- II.B.5.b).(3) **publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,** ^(Detail)
- II.B.5.b).(4) **participation in national committees or educational organizations.** ^(Detail)
- II.B.5.c) **Faculty should encourage and support fellows in scholarly activities.** ^(Core)

- II.B.5.d) There must be at least four members of the teaching staff who have experience and knowledge of the care of acute pediatric illness and injuries so as to: ^(Core)
- II.B.5.d).(1) provide adequate supervision of fellows, and, ^(Detail)
- II.B.5.d).(2) ensure the educational and research quality of the program. ^(Detail)
- II.B.5.e) The pediatric emergency medicine faculty must:
- II.B.5.e).(1) have an active role in curriculum development and in the supervision and evaluation of fellows; ^(Detail)
- II.B.5.e).(2) contribute both clinically and academically to the program; and, ^(Detail)
- II.B.5.e).(3) have protected time to allow for teaching and active participation in scholarly activity. ^(Detail)
- II.B.5.f) The program must ensure that fellows have access to consultants and collaborative faculty in related medical and surgical disciplines who have training and experience in the care of children and adolescents. ^(Detail)

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. ^(Core)

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. ^(Core)

- II.D.1. There must be an acute care facility that receives patients via ambulance from the pre-hospital setting, is equipped to handle trauma, and has the full range of services associated with residencies in pediatrics and emergency medicine. ^(Core)
- II.D.1.a) This facility should be accredited by the Joint Commission on Accreditation of Healthcare Organizations. ^(Detail)
- II.D.2. There must be comprehensive radiologic and laboratory support systems and readily available operative suites and intensive care unit beds. ^(Core)
- II.D.3. Patient Population
- II.D.3.a) The available patient population should encompass the full

spectrum of infants, children, adolescents, and young adults. ^(Core)

II.D.3.b) To meet the educational objectives of the program, there should be a minimum of 20,000 pediatric patient visits per year in the program's primary emergency department. ^(Core)

II.D.3.b).(1) The Review Committee will consider patient acuity and the total number of trainees in assessing the adequacy of the patient population.

II.D.3.c) The population must include a sufficient number of acutely ill patients with major and minor trauma, airway insufficiency, ingestions, obstetric and gynecologic disorders, psychosocial disturbances, and emergent problems from all pediatric medical and surgical subspecialties. ^(Core)

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. ^(Detail)

III. Fellow Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for fellow eligibility as specified in the Institutional Requirements. ^(Core)

III.A.1. Prerequisite training should include satisfactory completion of an ACGME or Royal College of Physicians and Surgeons of Canada accredited residency program in either emergency medicine or pediatrics. ^(Core)

III.A.2. The program should inform fellows in writing as to the length of their curriculum before they begin the fellowship. ^(Core)

III.B. Number of Fellows

The program's educational resources must be adequate to support the number of fellows appointed to the program. ^(Core)

III.B.1. **The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements.** ^(Core)

III.C. Fellow Transfers

III.C.1. **Before accepting a fellow who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring fellow.** ^(Detail)

III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for fellows who may leave the program prior to completion. ^(Detail)

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, fellows from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed fellows' education. ^(Core)

III.D.1. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines. ^(Detail)

IV. Educational Program

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

IV.A.1. Overall educational goals for the program, which the program must make available to fellows and faculty; ^(Core)

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to fellows and faculty at least annually, in either written or electronic form; ^(Core)

IV.A.3. Regularly scheduled didactic sessions; ^(Core)

IV.A.3.a) Multidisciplinary conferences should include lectures, morbidity and mortality conferences, case conferences, general reviews, and research seminars. ^(Detail)

IV.A.3.a).(1) The program must include education in related basic sciences, including physiology, growth and development, pathophysiology, and the epidemiology and prevention of pediatric illnesses and injuries. ^(Detail)

IV.A.3.a).(2) Fellows should attend conferences related to understanding diversity, family presence during resuscitations, cultural competence, professionalism, communication skills, the giving and receiving of feedback, and self-directed assessment and learning. ^(Detail)

IV.A.3.a).(3) The program should also provide education on physician wellness and stress management. ^(Detail)

IV.A.3.b) Faculty and fellows' attendance must be documented. ^(Detail)

| IV.A.3.c) Both faculty members and fellows must participate meaningfully in the didactic activities offered by the program. ^(Detail)

IV.A.3.c).(1) Subspecialty conferences must be regularly scheduled, and should involve active participation by the fellows in the planning and implementation of these meetings. ^(Detail)

IV.A.4. Delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and supervision of fellows over the continuum of the program; and, ^(Core)

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: ^(Core)

IV.A.5.a) Patient Care and Procedural Skills

IV.A.5.a).(1) 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: ^(Outcome)

IV.A.5.a).(1).(a) must competently perform a history and physical examination, make diagnostic and therapeutic decisions, develop and carry out management plans, counsel patients and families, and use information technology to optimize patient care; ^(Outcome)

IV.A.5.a).(1).(b) must demonstrate competence in providing initial evaluation and treatment to all kinds of patients. Fellows must evaluate the patient with an undifferentiated chief complaint and diagnose whether it falls in areas traditionally designated medical, surgical or subspecialty. Fellows must perform such evaluations rapidly, with simultaneous stabilization of any life threatening process, and to proceed with appropriate life-saving interventions before arriving at a definitive diagnosis; ^(Outcome)

IV.A.5.a).(1).(c) must have supervised experience to demonstrate competence in performing and interpreting the results of laboratory tests and diagnostic procedures for use in patient care; ^(Outcome)

| IV.A.5.a).(1).(d) must demonstrate, under faculty [member](#) supervision, the skills appropriate to a supervisor, teacher, and decision maker in pediatric emergencies in the final year of education; ^(Outcome)

IV.A.5.a).(1).(e) must assume leadership responsibility for the pediatric emergency department; ^(Outcome)

- IV.A.5.a).(1).(f) must demonstrate competence when providing supervision and consultation to other residents caring for patients in the emergency department; and, ^(Outcome)
- IV.A.5.a).(1).(g) must demonstrate competence in compassionate understanding of the stress associated with sudden illness, injury, and death so that they are responsive to the emotional needs of patients, their families, and the emergency department staff. ^(Outcome)
- IV.A.5.a).(2)** **Fellows must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Fellows:** ^(Outcome)
- IV.A.5.a).(2).(a) must demonstrate competence in the skills necessary to prioritize and simultaneously manage the emergency care of multiple patients; ^(Outcome)
- IV.A.5.a).(2).(b) must demonstrate competency in technical/procedural and resuscitation skills for pediatric patients of all ages; ^(Outcome)
- IV.A.5.a).(2).(c) must attain competency in the following procedures:
- IV.A.5.a).(2).(c).(i) abscess incision and drainage; ^(Outcome)
- IV.A.5.a).(2).(c).(ii) arterial catheterization; ^(Outcome)
- IV.A.5.a).(2).(c).(iii) arthrocentesis; ^(Outcome)
- IV.A.5.a).(2).(c).(iv) artificial ventilation; ^(Outcome)
- IV.A.5.a).(2).(c).(v) cardiac pacing, external; ^(Outcome)
- IV.A.5.a).(2).(c).(vi) cardiopulmonary resuscitation in all of the following groups: ^(Outcome)
- IV.A.5.a).(2).(c).(vi).(a) pediatric medical resuscitation <2 years; ^(Outcome)
- IV.A.5.a).(2).(c).(vi).(b) pediatric medical resuscitation 2-18 years; ^(Outcome)
- IV.A.5.a).(2).(c).(vi).(c) adult medical resuscitation >18 years; ^(Outcome)

IV.A.5.a).(2).(c).(vi).(d)	pediatric trauma resuscitation <2 years; ^(Outcome)
IV.A.5.a).(2).(c).(vi).(e)	pediatric trauma resuscitation 2-18 years; and, ^(Outcome)
IV.A.5.a).(2).(c).(vi).(f)	adult trauma resuscitation >18 years; ^(Outcome)
IV.A.5.a).(2).(c).(vii)	cardioversion/defibrillation; ^(Outcome)
IV.A.5.a).(2).(c).(viii)	central venous catheterization; ^(Outcome)
IV.A.5.a).(2).(c).(ix)	closed reduction/splinting; ^(Outcome)
IV.A.5.a).(2).(c).(x)	conversion of supraventricular tachycardia; ^(Outcome)
IV.A.5.a).(2).(c).(xi)	cricothyrotomy – translaryngeal ventilation; ^(Outcome)
IV.A.5.a).(2).(c).(xii)	dislocation/reduction; ^(Outcome)
IV.A.5.a).(2).(c).(xiii)	endotracheal intubation; ^(Outcome)
IV.A.5.a).(2).(c).(xiv)	foreign body removal; ^(Outcome)
IV.A.5.a).(2).(c).(xv)	gastric lavage; ^(Outcome)
IV.A.5.a).(2).(c).(xvi)	gastrostomy tube replacement; ^(Outcome)
IV.A.5.a).(2).(c).(xvii)	intraosseous access; ^(Outcome)
IV.A.5.a).(2).(c).(xviii)	laceration repair; ^(Outcome)
IV.A.5.a).(2).(c).(xix)	pericardiocentesis; ^(Outcome)
IV.A.5.a).(2).(c).(xx)	nasal packing; ^(Outcome)
IV.A.5.a).(2).(c).(xxi)	peritoneal lavage; ^(Outcome)
IV.A.5.a).(2).(c).(xxii)	rapid sequence intubation; ^(Outcome)
IV.A.5.a).(2).(c).(xxiii)	regional nerve blocks; ^(Outcome)
IV.A.5.a).(2).(c).(xxiv)	sedation and analgesia; ^(Outcome)
IV.A.5.a).(2).(c).(xxv)	slit lamp examination; ^(Outcome)
IV.A.5.a).(2).(c).(xxvi)	tracheostomy tube replacement; ^(Outcome)

- IV.A.5.a).(2).(c).(xxvii) tube thoracostomy; (Outcome)
- IV.A.5.a).(2).(c).(xxviii) umbilical vessel catheterization; and, (Outcome)
- IV.A.5.a).(2).(c).(xxix) vaginal delivery. (Outcome)

IV.A.5.b) Medical Knowledge

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows: (Outcome)

- IV.A.5.b).(1) must demonstrate knowledge of the clinical and basic sciences as related to pediatric emergency medicine. (Outcome)

IV.A.5.c) Practice-based Learning and Improvement

Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. (Outcome)

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

- IV.A.5.c).(1) **identify strengths, deficiencies, and limits in one's knowledge and expertise;** (Outcome)
- IV.A.5.c).(2) **set learning and improvement goals;** (Outcome)
- IV.A.5.c).(3) **identify and perform appropriate learning activities;** (Outcome)
- IV.A.5.c).(4) **systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;** (Outcome)
- IV.A.5.c).(5) **incorporate formative evaluation feedback into daily practice;** (Outcome)
- IV.A.5.c).(6) **locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;** (Outcome)
- IV.A.5.c).(7) **use information technology to optimize learning;** (Outcome)
- IV.A.5.c).(8) **participate in the education of patients, families,**

**students, residents and other health professionals;
and,** ^(Outcome)

IV.A.5.c).(9) teach by conducting lectures, seminars, and clinical conferences and by preparing written reports and teaching materials; ^(Outcome)

IV.A.5.c).(10) participate in clinical and/or professional quality improvement activities. Evidence of self-evaluation, incorporating faculty, peer, and patient assessments, must be demonstrated in the fellow's development of his or her individual learning plan; and, ^(Outcome)

IV.A.5.c).(11) teach and participate in undergraduate, graduate, and continuing education activities, as well as assume some departmental administrative responsibilities. ^(Outcome)

IV.A.5.d) Interpersonal and Communication Skills

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. ^(Outcome)

Fellows are expected to:

IV.A.5.d).(1) **communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;** ^(Outcome)

IV.A.5.d).(2) **communicate effectively with physicians, other health professionals, and health related agencies;** ^(Outcome)

IV.A.5.d).(3) **work effectively as a member or leader of a health care team or other professional group;** ^(Outcome)

IV.A.5.d).(4) **act in a consultative role to other physicians and health professionals;** ^(Outcome)

IV.A.5.d).(5) **maintain comprehensive, timely, and legible medical records, if applicable; and,** ^(Outcome)

IV.A.5.d).(6) demonstrate competence in the unique roles of the consultant, team leader, and team member. ^(Outcome)

IV.A.5.e) Professionalism

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

Fellows are expected to demonstrate:

- IV.A.5.e).(1)** **compassion, integrity, and respect for others;** ^(Outcome)
- IV.A.5.e).(2)** **responsiveness to patient needs that supersedes self-interest;** ^(Outcome)
- IV.A.5.e).(3)** **respect for patient privacy and autonomy;** ^(Outcome)
- IV.A.5.e).(4)** **accountability to patients, society and the profession;** ^(Outcome)
- IV.A.5.e).(5)** **sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation; and,** ^(Outcome)
- IV.A.5.e).(6)** **high standards of professionalism and a commitment to continued improvement.** ^(Outcome)

IV.A.5.f) Systems-based Practice

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. ^(Outcome)

Fellows are expected to:

- IV.A.5.f).(1)** **work effectively in various health care delivery settings and systems relevant to their clinical specialty;** ^(Outcome)
- IV.A.5.f).(2)** **coordinate patient care within the health care system relevant to their clinical specialty;** ^(Outcome)
- IV.A.5.f).(3)** **incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;** ^(Outcome)
- IV.A.5.f).(4)** **advocate for quality patient care and optimal patient care systems;** ^(Outcome)
- IV.A.5.f).(5)** **work in interprofessional teams to enhance patient safety and improve patient care quality;** ^(Outcome)
- IV.A.5.f).(6)** **participate in identifying system errors and implementing potential systems solutions;** ^(Outcome)
- IV.A.5.f).(7)** **demonstrate competence in the economics of health care**

and current health care management issues including cost-effective patient care, practice management, preventive care, quality improvement, resource allocation, and clinical outcomes; and, ^(Outcome)

IV.A.5.f).(8) demonstrate competence in the prevention of medical errors. ^(Outcome)

IV.A.6. Curriculum Organization and Fellow Experiences

IV.A.6.a) Agreements Between Programs

There must be written agreements between the director of the program in pediatric emergency medicine and the directors of the participating residencies in pediatrics and emergency medicine specifying the experiences that will comprise this subspecialty program. These agreements should address appropriate curriculum content, supervision of fellows, amount and distribution of clinical and non-clinical time, conferences, clinical performance criteria, and mechanisms for resolving performance problems.

^(Detail)

IV.A.6.b) Length of Curriculum

Emergency medicine sponsored programs that wish to accept pediatrics trained graduates must specify two residency curricula: a two-year curriculum for emergency medicine graduates and a three-year curriculum for pediatrics graduates. ^(Core)

IV.A.6.c) Reciprocal Training

Specialty-specific content must include at least four months of training in the specialty reciprocal to the fellow's prior residency. ^(Core)

IV.A.6.c).(1) For the emergency medicine graduate, reciprocal time must include four months spent in pediatric subspecialty and ambulatory clinics and in the management of critically ill neonates and children in an ACGME-accredited pediatric residency program. ^(Detail)

IV.A.6.c).(2) For the pediatrics graduate, reciprocal time must include four months spent in an adult emergency department that is part of an ACGME-accredited emergency medicine residency program. One block month of that experience must be spent caring for adults with traumatic injuries, ideally on a trauma service. During the time spent in the adult emergency department, there must be structured educational experiences in emergency medical services and toxicology. These should include both didactic and experiential components that may be longitudinally

integrated into other parts of the curriculum or designed as block rotations. ^(Detail)

IV.A.6.c).(3) Additional elective months of reciprocal training should be scheduled when deemed necessary by the program director to ensure fellows acquire the essential skills of a pediatric emergency specialist. ^(Detail)

IV.A.6.d) Program Design

IV.A.6.d).(1) Fellows in pediatric emergency medicine must participate in the care of pediatric patients of all ages, from infancy through young adulthood, and with a broad spectrum of illnesses and injuries of all severities. ^(Core)

IV.A.6.d).(2) At least 12 months of the clinical experience must be obtained seeing children in an emergency department where patients, ages 21 years of age or younger, are treated for the full spectrum of illnesses and injuries. ^(Core)

IV.A.6.d).(3) Fellows must be given progressive responsibility for patient care as they advance through the program. ^(Core)

IV.A.6.d).(4) The fellows' training must include experience with blunt and penetrating trauma, significant gynecologic and obstetrical emergencies, as well as psychiatric emergencies of the adolescent. ^(Detail)

IV.A.6.d).(5) The core content of the program must include training in emergency medical services for children (EMSC), administration, legal issues, procedures, patient safety, medical errors, ethics, and professionalism. ^(Detail)

IV.A.6.d).(6) The curriculum must also include experiences in cardiopulmonary resuscitation; trauma; disaster and environmental medicine; transport; triage; sedation; emergencies arising from toxicologic, obstetric, gynecologic, allergic/immunologic, cardiovascular, congenital, dermatologic, dental, endocrine/metabolic, gastrointestinal, hematologic/oncologic, infectious, musculoskeletal, neurologic, ophthalmic, psychosocial, and pulmonary causes; renal/genitourinary and surgical disorders; and physical and sexual abuse. ^(Detail)

IV.A.6.d).(7) The educational program must be organized and conducted in a way that ensures an appropriate environment for the well-being and care of patients and their families, while providing fellows the opportunity to become skilled clinicians, competent teachers, and knowledgeable investigators. ^(Detail)

- IV.A.6.d).(8) The program must emphasize the fundamentals of assessment, diagnosis, and management. ^(Detail)
- IV.A.6.d).(9) Fellows must have supervised experience in performing and interpreting the results of laboratory tests and diagnostic procedures for use in patient care. ^(Core)
- IV.A.6.d).(10) Fellows must have instruction and experience to acquire the necessary procedural skills and to develop an understanding of laboratory tests and diagnostic procedures, indications, risks, and limitations. ^(Core)
- IV.A.6.d).(11) Fellows should also be exposed to academic debate, intensive research review, and interaction between the specialties of pediatrics and emergency medicine. ^(Detail)
- IV.A.6.d).(12) For a subspecialty program that functions as an integral part of a pediatric residency program, there must be adequate exposure to faculty who are certified by the ABEM. Conversely, for a subspecialty program based in an emergency medicine residency program, there must be adequate exposure to faculty certified by the ABP. ^(Core)
- IV.A.6.d).(12).(a) Fellows must be exposed to both ABEM-certified faculty and ABP-certified faculty over the course of the residency, both didactically and in the clinical management of acutely ill and injured patients. ^(Detail)
- IV.A.6.d).(13) There should be opportunities to participate in regularly scheduled, multi-disciplinary conferences. ^(Detail)
- IV.A.6.d).(14) The program must foster professionalism throughout training. The formal curriculum must include bioethics, including attention to physician-patient, physician-family, physician-physician/allied health professional, and physician-society relationships. ^(Detail)
- IV.A.6.d).(14).(a) Discussion and appreciation of ethical issues involved in pediatric emergency medicine should be part of the educational program. ^(Detail)
- IV.A.6.d).(15) There should be instruction in curriculum design, information delivery in clinical settings and classrooms, provision of feedback to learners, assessment of educational outcomes, and the development of teaching materials. ^(Detail)
- IV.A.6.d).(16) Instruction in Program Administration
- IV.A.6.d).(16).(a) Fellows should have formal sessions on organizing teaching programs, medical writing, and oral

presentation. ^(Detail)

IV.A.6.d).(16).(b) Fellows must receive instruction and experience in administrative and management skills, including quality improvement principles, necessary to oversee a division or department. ^(Detail)

IV.A.6.d).(17) Fellows should receive instruction in such topics as the economics of health care and current health care management issues, such as cost-effective patient care, practice management, preventive care, quality improvement, resource allocation, and clinical outcomes. ^(Detail)

IV.A.6.d).(18) Fellows should receive didactic instruction and experience in the prevention of medical errors. ^(Detail)

IV.B. Fellows' Scholarly Activities

IV.B.1. The curriculum must advance fellows' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. ^(Core)

IV.B.2. Fellows should participate in scholarly activity. ^(Core)

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate fellow involvement in scholarly activities. ^(Detail)

V. Evaluation

V.A. Fellow Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee. ^(Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. ^(Core)

V.A.1.a).(1) Others eligible for appointment to the committee include faculty from other programs and non-physician members of the health care team. ^(Detail)

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee. ^(Core)

V.A.1.b).(1) The Clinical Competency Committee should:

V.A.1.b).(1).(a) review all fellow evaluations semi-annually; ^(Core)

V.A.1.b).(1).(b) prepare and assure the reporting of Milestones evaluations of each fellow semi-annually to ACGME; and, ^(Core)

V.A.1.b).(1).(c) advise the program director regarding fellow progress, including promotion, remediation, and dismissal. ^(Detail)

V.A.2. Formative Evaluation

V.A.2.a) The faculty must evaluate fellow performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment. ^(Core)

V.A.2.b) The program must:

V.A.2.b).(1) provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; ^(Core)

V.A.2.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); ^(Detail)

V.A.2.b).(3) document progressive fellow performance improvement appropriate to educational level; and, ^(Core)

V.A.2.b).(4) provide each fellow with documented semiannual evaluation of performance with feedback. ^(Core)

V.A.2.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy. ^(Detail)

V.A.2.c).(1) To ensure an acceptable level of fellow performance and procedural and resuscitation competency, the program must:

V.A.2.c).(1).(a) discuss assessment tools, measurement process and outcomes with each fellow; ^(Detail)

V.A.2.c).(1).(b) document performance and procedural and resuscitation competency in fellow files; and, ^(Detail)

V.A.2.c).(1).(c) maintain documentation of these activities for review with the site visitor at the time of the site visit. ^(Detail)

V.A.2.c).(2) These efforts must be reviewed and evaluated by the supervising faculty in light of using competency-based objectives developed by the program. ^(Detail)

V.A.3. Summative Evaluation

V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure fellows are able to practice core professional activities without supervision upon completion of the program. ^(Core)

V.A.3.b) The program director must provide a summative evaluation for each fellow upon completion of the program. ^(Core)

This evaluation must:

V.A.3.b).(1) 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; ^(Detail)

V.A.3.b).(2) document the fellow's performance during the final period of education; and, ^(Detail)

V.A.3.b).(3) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision. ^(Detail)

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program. ^(Core)

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. ^(Detail)

V.B.3. This evaluation must include at least annual written confidential evaluations by the fellows. ^(Detail)

V.B.4. Faculty should receive formal feedback from these evaluations. ^(Detail)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee (PEC). ^(Core)

V.C.1.a) The Program Evaluation Committee:

V.C.1.a).(1) must be composed of at least two program faculty

- members and should include at least one fellow; ^(Core)
- V.C.1.a).(2) must have a written description of its responsibilities; and, ^(Core)
- V.C.1.a).(3) should participate actively in:
- V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; ^(Detail)
- V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; ^(Detail)
- V.C.1.a).(3).(c) addressing areas of non-compliance with ACGME standards; and, ^(Detail)
- V.C.1.a).(3).(d) reviewing the program annually using evaluations of faculty, fellows, and others, as specified below. ^(Detail)
- V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation (APE). ^(Core)
- The program must monitor and track each of the following areas:
- V.C.2.a) fellow performance; ^(Core)
- V.C.2.b) faculty development; ^(Core)
- V.C.2.c) graduate performance, including performance of program graduates on the certification examination; ^(Core)
- V.C.2.d) program quality; and, ^(Core)
- V.C.2.d).(1) Fellows and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and ^(Detail)
- V.C.2.d).(2) The program must use the results of fellows' and faculty members' assessments of the program together with other program evaluation results to improve the program. ^(Detail)
- V.C.2.e) progress on the previous year's action plan(s). ^(Core)
- V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and

monitored ^(Core)

- V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.** ^(Detail)
- V.C.4. The annual evaluation should include an assessment of resources available to the program. ^(Core)
- V.C.4.a) The contribution of participating sites, the financial and administrative support of the program, the volume and variety of patients available for educational purposes, the performance of teaching staff, and the quality of supervision of fellows should all be considered in the evaluation. ^(Detail)
- V.C.4.b) Information gained from these evaluations should be used to implement improvements in the program. ^(Outcome)
- V.C.5. The same evaluation mechanisms used in the related residency program must be adapted for and implemented in the pediatric emergency medicine program that function with it. ^(Core)
- V.C.5.a) In order to maintain the confidentiality of responses from fellows in small programs, evaluations of faculty may be consolidated with the core faculty evaluations. ^(Detail)

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.** ^(Core)
- VI.A.2. The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational environment.** ^(Core)
- VI.A.3. The program director must ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.** ^(Core)
- 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,** ^(Core)
- VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill non-physician service obligations.** ^(Core)

- VI.A.5.** The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. ^(Core)
- VI.A.6.** Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:
- VI.A.6.a)** assurance of the safety and welfare of patients entrusted to their care; ^(Outcome)
 - VI.A.6.b)** provision of patient- and family-centered care; ^(Outcome)
 - VI.A.6.c)** assurance of their fitness for duty; ^(Outcome)
 - VI.A.6.d)** management of their time before, during, and after clinical assignments; ^(Outcome)
 - VI.A.6.e)** recognition of impairment, including illness and fatigue, in themselves and in their peers; ^(Outcome)
 - VI.A.6.f)** attention to lifelong learning; ^(Outcome)
 - VI.A.6.g)** the monitoring of their patient care performance improvement indicators; and, ^(Outcome)
 - VI.A.6.h)** honest and accurate reporting of duty hours, patient outcomes, and clinical experience data. ^(Outcome)
- VI.A.7.** All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. They 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. ^(Outcome)
- VI.B. Transitions of Care**
- VI.B.1.** Programs must design clinical assignments to minimize the number of transitions in patient care. ^(Core)
 - 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. ^(Core)
 - VI.B.3.** Programs must ensure that fellows are competent in communicating with team members in the hand-over process. ^(Outcome)
 - 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. ^(Detail)

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; ^(Core)

VI.C.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and, ^(Core)

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. ^(Detail)

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. ^(Core)

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. ^(Core)

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. ^(Core)

VI.D.1.a) This information should be available to fellows, faculty members, and patients. ^(Detail)

VI.D.1.b) Fellows and faculty members should inform patients of their respective roles in each patient's care. ^(Detail)

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients. ^(Core)

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 or 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. ^(Detail)

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: ^(Core)

- VI.D.3.a) **Direct Supervision – the supervising physician is physically present with the fellow and patient.** ^(Core)
- 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.** ^(Core)
 - 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.** ^(Core)
- VI.D.3.c) **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.** ^(Core)
- 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.** ^(Core)
 - 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.** ^(Core)
 - 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.** ^(Detail)
 - VI.D.4.c) **Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.** ^(Detail)
- 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.** ^(Core)
 - 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. ^(Outcome)

VI.D.5.a).(1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. ^(Core)

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. ^(Detail)

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. ^(Core)

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. ^(Core)

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. ^(Core)

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. ^(Detail)

The Review Committee for Emergency Medicine will not consider requests for exceptions to the 80-hour limit to the fellows' work week.

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. ^(Detail)

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. ^(Detail)

- 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. ^(Core)**
- 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. ^(Core)**
- VI.G.2.c) PGY-1 residents are not permitted to moonlight. ^(Core)**
- 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. ^(Core)**
- VI.G.4. Maximum Duty Period Length**
- VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration. ^(Core)**
- VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. ^(Core)**
- VI.G.4.b).(1) 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. ^(Detail)**
- VI.G.4.b).(2) 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. ^(Core)**
- VI.G.4.b).(3) Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. ^(Core)**
- VI.G.4.b).(4) 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. ^(Detail)

VI.G.4.b).(4).(a) Under those circumstances, the fellow must:

VI.G.4.b).(4).(a).(i) appropriately hand over the care of all other patients to the team responsible for their continuing care; and, ^(Detail)

VI.G.4.b).(4).(a).(ii) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. ^(Detail)

VI.G.4.b).(4).(b) The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty. ^(Detail)

VI.G.5. Minimum Time Off between Scheduled Duty Periods

VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. ^(Core)

VI.G.5.b) Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. ^(Core)

VI.G.5.c) Fellows in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. ^(Outcome)

Emergency medicine fellows are considered to be in the final years of education.

VI.G.5.c).(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 in their final years of education 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. ^(Detail)

VI.G.5.c).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by fellows in their final years of education must be monitored by the program director. ^(Detail)

VI.G.5.c).(1).(b)

The Review Committee defines such circumstances as required continuity of care for a severely ill or unstable patient, or a complex patient with whom the fellow has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

VI.G.6. Maximum Frequency of In-House Night Float

Fellows must not be scheduled for more than six consecutive nights of night float. ^(Core)

VI.G.7. Maximum In-House On-Call Frequency

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period). ^(Core)

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. ^(Core)

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. ^(Core)

VI.G.8.b) Residents 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”. ^(Detail)

***Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.