ACGME Program Requirements for Graduate Medical Education in Micrographic Surgery and Dermatologic Oncology including FAQs

Revision Information

Frequently asked questions (FAQs) incorporated into the Requirements July 1, 2026; effective July 1, 2026

ACGME-approved interim revision February 9, 2026; effective immediately. Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirements 1.3.a., 2.2.a., 2.7.c., 4.2.a., 4.2.e., 5.5.f., 5.5.h., 6.24., and 6.24.a. has been suspended. See explanatory text under 1.2. for modifications to this and related specialty-specific requirements.

ACGME-approved interim revision September 29, 2025; effective July 1, 2026

Definitions

For more information, see the ACGME Glossary of Terms.

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 and sponsoring institutions 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.

Osteopathic Recognition

For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements also apply (www.acgme.org/OsteopathicRecognition).

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ACGME Program Requirements for Graduate Medical Education

in Micrographic Surgery and Dermatologic Oncology

Common Program Requirements (One-Year Fellowship) are in BOLD

Where applicable, italicized text is used to provide definitions or describe the underlying philosophy of the requirements in that section. These statements are not program requirements and are therefore not citable.

> **Background and Intent: These fellowship requirements reflect the fact that these learners have already completed the first phase of graduate medical education. Thus, the Common Program Requirements (One-Year Fellowship) are intended to explain the differences.**

Introduction

Definition of Graduate Medical Education

Fellowship is advanced graduate medical education beyond a core residency program for physicians who desire to enter more specialized practice. Fellowship-trained physicians serve the public by providing subspecialty care, which may also include core medical care, acting as a community resource for expertise in their field, creating and integrating new knowledge into practice, and educating future generations of physicians. Graduate medical education values the strength that a heterogeneous group of physicians brings to medical care, and the importance of accessible and psychologically safe learning environments.

Fellows who have completed residency are able to practice autonomously in their core specialty. The prior medical experience and expertise of fellows distinguish them from physicians entering residency. The fellow's care of patients within the subspecialty is undertaken with appropriate faculty supervision and conditional independence. Faculty members serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship. The fellow develops deep medical knowledge, patient care skills, and expertise applicable to their focused area of practice. Fellowship is an intensive program of subspecialty clinical and didactic education that focuses on the multidisciplinary care of patients. Fellowship education is often physically, emotionally, and intellectually demanding, and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.

In addition to clinical education, many fellowship programs advance fellows' skills as physician-scientists. While the ability to create new knowledge within medicine is not exclusive to fellowship-educated physicians, the fellowship experience expands a physician's abilities to pursue hypothesis-driven scientific inquiry that results in contributions to the medical literature and patient care. Beyond the clinical subspecialty expertise ach-

ieved, fellows develop mentored relationships built on an infrastructure that promotes collaborative research.

Definition of Subspecialty

Micrographic surgery and dermatologic oncology is the subspecialty of dermatology concerned with the study, diagnosis, and surgical treatment of malignancies of the skin and adjacent mucous membranes, cutaneous appendages, hair, nails, and subcutaneous tissue. A particular emphasis is the surgical and medical management of patients with high risk cutaneous malignancies. Micrographic surgery and dermatologic oncology is broadly categorized into the following areas:

- *Cutaneous oncologic surgery, which incorporates medical, surgical, and dermatopathological knowledge of cutaneous malignancies. An essential technique is Mohs micrographic surgical excision, which is used for certain cancers of the skin and incorporates education in clinical dermatology and dermatopathology as they apply to dermatologic surgery.*
- *Cutaneous reconstructive surgery, which includes the repair of skin and subcutaneous defects that result from the surgical removal of tumors or other skin disease, scar revision, and restoration of the skin following skin surgery to its best possible appearance. This is based upon knowledge of cutaneous anatomy, wound healing, cutaneous repair techniques, and aesthetic procedures that improve the appearance of the skin following surgery.*
- *Dermatologic oncology, which incorporates knowledge of the clinical and pathologic diagnosis, staging, and treatment options for patients with cutaneous malignancies. This incorporates knowledge of cutaneous cancer syndromes and optimal management of cutaneous malignancies both surgical and non-surgical.*

Section 1: Oversight

Sponsoring Institution

The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education consistent with the ACGME Institutional Requirements.

When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.

Background and Intent: Participating sites will reflect the health care needs of the community and the educational needs of the fellows. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings including, but not limited to a university, a medical school, a teaching hospital, a nursing home, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, an educational consor-

tium, a teaching health center, a physician group practice, a federally qualified health center, a surgery center, an academic and private single-specialty clinic, or an educational foundation.

1.1. The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)

Participating Sites

A participating site is an organization providing educational experiences or educational assignments/rotations for fellows.

1.2. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)

1.3. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)

[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]

1.3.a. The PLA must be renewed at least every 10 years. (Core)

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 1.3.a has been suspended]

1.3.b. The PLA must be approved by the designated institutional official (DIO). (Core)

1.4. The program must monitor the clinical learning and working environment at all participating sites. (Core)

1.5. At each participating site there must be one faculty member, designated by the program director, who is accountable for fellow education for that site, in collaboration with the program director. (Core)

Background and Intent: While all fellowship programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must designate a faculty member responsible for ensuring the quality of the educational experience. In some circumstances, the person charged with this responsibility may not be physically present at the site, but remains responsible for fellow education occurring at the site.

Suggested elements to be considered in PLAs will be found in the Guide to the Common Program Requirements. These include:

- **Identifying the faculty members who will assume educational and supervisory responsibility for fellows**
- **Specifying the responsibilities for teaching, supervision, and formal evaluation of fellows**
- **Specifying the duration and content of the educational experience**
- **Stating the policies and procedures that will govern fellow education during the assignment**

1.6. 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 ACGME's Accreditation Data System (ADS). (Core)

1.7. Resources

The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for fellow education. (Core)

1.7.a. Adequate space must be dedicated to the performance of dermatologic surgery procedures, and must include a Mohs micrographic frozen section laboratory and examination areas for surgical patients. (Core)

1.7.a.1. The space should be accredited by the appropriate oversight bodies as required by federal, state, and local laws. (Detail)

1.7.a.2. The frozen section laboratory must be adjacent to the operating suite or rooms in which dermatologic surgery is performed. (Core)

1.7.a.3. Program laboratories must be in compliance with all federal, state, and local regulations regarding a work environment. (Core)

1.7.b. Frozen section slides for Mohs micrographic surgery must be reviewed and approved, as part of an ongoing quality assurance process, by an appropriately qualified external organization or equivalent academic medical center's Quality Assessment and Control program that has experience reviewing the unique method of histology slide preparation required to perform Mohs surgery. (Core)
[See FAQ in Appendix]

1.7.c. Quality Assurance/Quality Control must include formal evaluation and written comments regarding slide quality, to include tissue thickness, completeness of epidermal edges, quality of sections of fat, staining quality, lack of holes in sections, accuracy of staining and mapping of section, and concordance with interpretation by the fellows the slides. (Core)

1.7.d. There should be appropriate space for fellows to read, study, and complete their paperwork. (Detail)

1.7.e. The program must provide a sufficient volume and variety of surgical cases. (Core)

1.7.e.1. At least 1000 dermatologic surgical procedures per fellow must be available. (Core)

1.7.e.2. At least 650 of that minimum total must be Mohs micrographic surgery procedures. (Core)

1.8. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote fellow well-being and provide for:

1.8.a. access to food while on duty; (Core)

1.8.b. safe, quiet, clean, and private sleep/rest facilities available and accessible for fellows with proximity appropriate for safe patient care, if the fellows are assigned in-house call; (Core)

> **Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that fellows function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while fellows are working. Fellows should have access to refrigeration where food may be stored. Food should be available when fellows are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued fellow.**

1.8.c. clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)

> **Background and Intent: Sites must provide private and clean locations where fellows may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the fellow with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the fellow and the fellow's family, as outlined in 6.13.c.1.**

1.8.d. security and safety measures appropriate to the participating site; and, (Core)

1.8.e. **accommodations for fellows with disabilities consistent with the Sponsoring Institution's policy.** (Core)

1.9. **Fellows must have ready access to subspecialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities.** (Core)

1.10. **Other Learners and Health Care Personnel**

The presence of other learners and health care personnel, including but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed fellows' education. (Core)

Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and postgraduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that fellows' education is not compromised by the presence of other providers and learners, and that fellows' education does not compromise core residents' education.

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

Section 2: Personnel

2.1. **Program Director**

There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)

2.2. **The Sponsoring Institution's Graduate Medical Education Committee (GMEC) must approve a change in program director and must verify the program director's licensure and clinical appointment.** (Core)

Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a fellowship, a single individual must be designated as program director and have overall responsibility for the program. The program director's nomination is reviewed and approved by the GMEC.

2.3. The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)

2.3.a. At a minimum, the program director must be provided with support equal to a dedicated minimum of 0.2 FTE for administration of the program. (Core)

Background and Intent: To achieve successful graduate medical education, individuals serving as education and administrative leaders of fellowship programs, as well as those significantly engaged in the education, supervision, evaluation, and mentoring of fellows, must have sufficient dedicated professional time to perform the vital activities required to sustain an accredited program.

The ultimate outcome of graduate medical education is excellence in fellow education and patient care.

The program director and, as applicable, the program leadership team, devote a portion of their professional effort to the oversight and management of the fellowship program, as defined in 2.5. – 2.5.l. Both provision of support for the time required for the leadership effort and flexibility regarding how this support is provided are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.

Program directors and, as applicable, members of the program leadership team, who are new to the role may need to devote additional time to program oversight and management initially as they learn and become proficient in administering the program. It is suggested that during this initial period the support described above be increased as needed.

In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a *minimum*, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program director, is also addressed in Institutional Requirement 2.2.a. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program directors to fulfill their program responsibilities effectively.

2.4. Qualifications of the Program Director

The program director must possess subspecialty expertise and qualifications acceptable to the Review Committee. (Core)

[See FAQ in Appendix]

2.4.a. **The program director must possess current certification in the subspecialty for which they are the program director by the American Board of** Dermatology **or by the American Osteopathic Board of** Dermatology**, or subspecialty qualifications that are acceptable to the Review Committee.** **(Core)**
[See FAQ in Appendix]

2.4.b. This must include completion of an ACGME- or AOA-accredited procedural dermatology or micrographic surgery and dermatologic oncology fellowship, an American College of Mohs Surgery-approved fellowship, or experience as a program director of a dermatologic surgery fellowship program for at least 10 years. (Core)

2.4.c. This must include at least six years of patient care experience as a dermatologist and dermatologic surgeon. (Core)

2.4.d. This must include at least three years of experience as a teacher in graduate medical education in dermatology and dermatologic surgery. (Core)

2.4.e. This must include an ongoing clinical practice in micrographic surgery and dermatologic oncology that includes personal performance of key aspects of micrographic surgery and dermatologic oncology as the fellow observes. (Core)
[See FAQ in Appendix]

2.5. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; fellow recruitment and selection, evaluation, and promotion of fellows, and disciplinary action; supervision of fellows; and fellow education in the context of patient care. **(Core)**

2.5.a. **The program director must be a role model of professionalism.** **(Core)**

Background and Intent: The program director, as the leader of the program, must serve as a role model to fellows in addition to fulfilling the technical aspects of the role. As fellows are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

2.5.b. **The program director must design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program.** **(Core)**

Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and eliminating health disparities.

2.5.c. The program director must administer and maintain a learning environment conducive to educating the fellows in each of the ACGME Competency domains. (Core)

Background and Intent: The program director may establish a leadership team to assist in the accomplishment of program goals. Fellowship programs can be highly complex. In a complex organization the leader typically has the ability to delegate authority to others, yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.

2.5.d. The program director must have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval. (Core)

Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of fellows by non-physician educators may enable the fellows to better manage patient care and provides valuable advancement of the fellows' knowledge. Furthermore, other individuals contribute to the education of fellows in the basic science of the subspecialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the fellow, the program director may designate the individual as a program faculty member or a program core faculty member.

2.5.e. The program director must have the authority to remove fellows from supervising interactions and/or learning environments that do not meet the standards of the program. (Core)

Background and Intent: The program director has the responsibility to ensure that all who educate fellows effectively role model the Core Competencies. Working with a fellow is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.

There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.

2.5.f. **The program director must submit accurate and complete information required and requested by the DIO, GMEC, and ACGME. (Core)**

Background and Intent: This includes providing information in the form and format requested by the ACGME and obtaining requisite sign-off by the DIO.

2.5.g. **The program director must provide a learning and working environment in which fellows have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation. (Core)**

2.5.h. **The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, not to promote or renew the appointment of a fellow. (Core)**

Background and Intent: A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures, and will ensure they are followed by the program's leadership, faculty members, support personnel, and fellows.

2.5.i. **The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination. (Core)**

2.5.j. **The program director must document verification of education for all fellows within 30 days of completion of or departure from the program. (Core)**

2.5.k. **The program director must provide verification of an individual fellow's education upon the fellow's request, within 30 days. (Core)**

Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of fellows who have previously completed the program. Fellows who leave the program prior to completion also require timely documentation of their summative evaluation.

Faculty

Faculty members are a foundational element of graduate medical education – faculty members teach fellows how to care for patients. Faculty members provide an important

bridge allowing fellows to grow and become practice ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, fellows, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the fellows and themselves.

Background and Intent: "Faculty" refers to the entire teaching force responsible for educating fellows. The term "faculty," including "core faculty," does not imply or require an academic appointment.

Subspecialty-Specific Background and Intent: Because Mohs fellowships often have only two total Mohs surgeons on the faculty, including the program director, the Review Committee for Dermatology suggests that if the program director is absent for longer than six consecutive weeks, a Mohs surgeon who meets the qualification requirements of the program director assume responsibility for the education of fellows until the program director returns.

2.6. There must be a sufficient number of faculty members with competence to instruct and supervise all fellows. (Core)

2.6.a. In addition to the program director, there must be at least one faculty member who is actively involved in the clinical practice of cutaneous oncologic surgery. (Core)

2.6.b. A second faculty member should be a Mohs surgeon, an otolaryngologist, an ophthalmic plastic and reconstructive surgeon, or a plastic surgeon who is actively involved in the surgical management of cutaneous oncology patients. (Detail)

2.6.c. Other members of the faculty in related disciplines should include members from specialties with overlapping expertise, including at least two of the following: dermatology; dermatopathology; general surgery; medical oncology; ophthalmology; otolaryngology; ophthalmic plastic and reconstructive surgery (oculoplastic surgeons), plastic surgery and prosthetics, pathology, and radiation therapy. (Detail)

2.7. Faculty Responsibilities
Faculty members must be role models of professionalism. (Core)

2.7.a. Faculty members must demonstrate commitment to the delivery of safe, high-quality, cost-effective, patient-centered care. (Core)

Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.

2.7.b. **Faculty members must demonstrate a strong interest in the education of fellows, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities.** **(Core)**

2.7.c. **Faculty members must administer and maintain an educational environment conducive to educating fellows.** **(Core)**

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 2.7.c. has been suspended]

2.7.d. **Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.** **(Core)**

2.7.e. **Faculty members must pursue faculty development designed to enhance their skills.** **(Core)**

2.8. **Faculty Qualifications**

Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. **(Core)**

2.9. **Subspecialty Physician Faculty Members**

Subspecialty physician faculty members must have current certification in the subspecialty by the American Board of Dermatology **or the American Osteopathic Board of** Dermatology**, or possess qualifications judged acceptable to the Review Committee.** **(Core)**

2.9.a. **Any other specialty or subspecialty physician faculty members must have current certification in their specialty by the appropriate American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board, or possess qualifications judged acceptable to the Review Committee.** **(Core)**

2.9.b. Members of the faculty who have responsibility for fellow education in Mohs micrographic surgery must have completed a 12-month PGY-5 dermatologic surgery fellowship or have experience as a program director of a dermatologic surgery fellowship program for at least 10 years. (Core)

2.10. **Core Faculty**

Core faculty members must have a significant role in the education and supervision of fellows and must devote a significant portion of their entire effort to fellow

education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to fellows. (Core)

Background and Intent: Core faculty members are critical to the success of fellow education. They support the program leadership in developing, implementing, and assessing curriculum, mentoring fellows, and assessing fellows' progress toward achievement of competence in and the autonomous practice of the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program. Core faculty members may also be selected for their specific expertise and unique contributions to the program. Core faculty members are engaged in a broad range of activities, which may vary across programs and specialties. Core faculty members provide clinical teaching and supervision of fellows, and also participate in non-clinical activities related to fellow education and program administration. Examples of these non-clinical activities include, but are not limited to, interviewing and selecting fellow applicants, providing didactic instruction, mentoring fellows, simulation exercises, completing the annual ACGME Faculty Survey, and participating on the program's Clinical Competency Committee, Program Evaluation Committee, and other GME committees.

2.10.a. Faculty members must complete the annual ACGME Faculty Survey. (Core)

2.10.b. The program must maintain a ratio of at least one core faculty member to each fellow appointed to the program. (Core)

2.11. Program Coordinator

There must be administrative support for program coordination. (Core)

2.11.a. The program coordinator must be provided with support equal to a dedicated minimum of 0.2 FTE for administration of the program. (Core)

Background and Intent: The requirement does not address the source of funding required to provide the specified salary support.

2.12. Other Program Personnel

The program, in partnership with its Sponsoring Institution , must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)

Background and Intent: Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to main-

tain electronic communication for the program. These personnel may support more than one program in more than one discipline.

Section 3: Fellow Appointments

3.1. Fellows must not be required to sign a non-competition guarantee or restrictive covenant. (Core)

3.2. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, an AOA-approved residency program, a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or a Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency program located in Canada. (Core)

[See FAQ in Appendix]

3.2.a. Fellowship programs must receive verification of each entering fellow's level of competence in the required field using ACGME, ACGME-I, or CanMEDS Milestones evaluations from the core residency program. (Core)

Background and Intent: A reporting feature is available for fellowship programs within ADS to provide fellowship program directors access to the final Milestones report for an active fellow's most recently completed residency program. These reports are available to fellowship program directors in mid-July, and use of this system to retrieve the reports is encouraged. There are a few scenarios in which these reports may not be available, such as if a fellow completed residency in a program not accredited by the ACGME, if a fellow completed residency prior to the Milestones implementation, or if a fellow's previous experience could not be matched when entered into the program. For those without Milestones reports, programs must contact the specialty program director from the fellow's most recent residency program to obtain the required information. This new reporting feature can be found in ADS by logging in and navigating to the program's "Reports" tab, and then selecting the "Residency Milestone Retrieval" option.

3.2.a.1. Prior to appointment in the program, fellows must have successfully completed a residency program in dermatology that satisfies the requirements in 3.2. (Core)

3.2.b. Fellow Eligibility Exception

The Review Committee for Dermatology **will allow the following exception to the fellowship eligibility requirements:**

3.2.b.1. **An ACGME-accredited fellowship program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in 3.2., but who does meet all of the following additional qualifications and conditions: (Core)**

3.2.b.1.a. **evaluation by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and, (Core)**

3.2.b.1.b. **review and approval of the applicant's exceptional qualifications by the GMEC; and, (Core)**

[See FAQ in Appendix]

3.2.b.1.c. **verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification. (Core)**

3.2.b.2. **Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. (Core)**

Background and Intent: An exceptionally qualified international graduate applicant has (1) completed a residency program in the core specialty outside the continental United States that was not accredited by the ACGME, AOA, ACGME-I, RCPSC or CFPC, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; and/or (c) demonstrated leadership during or after residency. Applicants being considered for these positions must be informed of the fact that their training may not lead to certification by ABMS member boards or AOA certifying boards.

In recognition of the range of medical training around the world, this early evaluation of clinical competence required for these applicants ensures they can provide quality and safe patient care. Any gaps in competence should be addressed as per policies for fellows already established by the program in partnership with the Sponsoring Institution.

3.3. **Fellow Complement**

The program director must not appoint more fellows than approved by the Review Committee. (Core)

Background and Intent: Programs are required to request approval of all complement changes, whether temporary or permanent, by the Review

Committee through ADS. Permanent increases require prior approval from the Review Committee and temporary increases may also require approval. Specialty-specific instructions for requesting a complement increase are found in the "Documents and Resources" page of the applicable specialty section of the ACGME website.

Section 4: Educational Program

The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.

It is recognized that programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.

4.1. Length of Educational Program

The educational program in micrographic surgery and dermatologic oncology must be 12 months in length. (Core)

4.2. Educational Components

The curriculum must contain the following educational components:

4.2.a. a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, fellows, and faculty members; (Core)

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 4.2.a. has been suspended]

4.2.b. competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice in their subspecialty. These must be distributed, reviewed, and available to fellows and faculty members; (Core)

4.2.c. delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and graded supervision in their subspecialty; (Core)

Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

4.2.d. structured educational activities beyond direct patient care; and, (Core)

Background and Intent: Patient care-related educational activities, such as morbidity and mortality conferences, tumor boards, surgical planning conferences, case discussions, etc., allow fellows to gain medical knowledge directly applicable to the patients they serve. Programs should define those educational activities in which fellows are expected to participate and for which time is protected. Further specification can be found in 4.10. – 4.12.

4.2.e. formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 4.2.e. has been suspended]

ACGME Competencies

The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each subspecialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each subspecialty. The focus in fellowship is on subspecialty-specific patient care and medical knowledge, as well as refining the other competencies acquired in residency.

The program must integrate all ACGME Competencies into the curriculum.

4.3. ACGME Competencies – Professionalism

Fellows must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)

4.4. ACGME Competencies – Patient Care and Procedural Skills (Part A)

Fellows must be able to provide patient care that is patient- and family-centered, compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)

Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, fair, and designed to improve population health, while reducing per capita costs. In addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.

4.4.a. Fellows must demonstrate competence in making decisions regarding patient treatment, including instances in which the patient prefers to be referred or would benefit from referral to a different specialty or to a multidisciplinary team. (Core)
[See FAQ in Appendix]

4.5. ACGME Competencies – Patient Care and Procedural Skills (Part B)
Fellows must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)

4.5.a. Fellows must demonstrate competence in performing procedures and must be competent in skin neoplasm destruction techniques, excision, and Mohs micrographic surgery. (Core)

4.5.b. Fellows must be competent in cutaneous reconstructive surgery, including random pattern and axial flap repair, and partial and full thickness skin grafting. (Core)

4.5.c. Fellows must be competent in recognizing when a staged reconstructive technique is in the best interest of the patient and appropriately refer to other specialists if necessary. (Core)

4.5.d. Fellows must perform at least 500 Mohs micrographic surgeries and 500 reconstructions as the primary surgeon. (Core)

4.5.d.1. Of the 500 reconstructions, at least 50 must be advanced/complex cases, including: random pattern flap repair, grafts, including full and split thickness grafts, repairs at difficult anatomic sites, e.g., eyelids, lips, intraoral and repair of defects greater than 10 sq. cm. (Core)

4.5.e. Fellows must demonstrate advanced evaluation and management skills for all cutaneous surgical patients regardless of diagnosis, including pre-, peri-, and post-operative evaluation. (Core)

4.5.f. Fellows must demonstrate competence in the early identification of malignant skin lesions through visual morphologic recognition. (Core)

4.5.g. Fellows must demonstrate competence in interpretation of frozen sections of a variety of cutaneous cancers. (Core)

4.5.h. Fellows must demonstrate competence in the management, including multidisciplinary management, of a variety of cutaneous cancers, to include basal cell carcinoma, squamous cell carcinoma, melanoma, adnexal carcinoma, Merkel cell carcino-

ma, extramammary Paget's disease, Atypical fibroxanthoma, sebaceous carcinoma, and dermatofibrosarcoma protuberans (DFSP). (Core)

4.5.i. Fellows must demonstrate the ability to manage emergencies that occur during the care of patients, to include cardiac events and other life threatening medical emergencies. (Core)

4.6. ACGME Competencies – Medical Knowledge

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

4.6.a. Fellows must demonstrate knowledge of related disciplines, including surgical anatomy, sterilization of equipment, aseptic technique, anesthesia, closure materials, and instrumentation. (Core)

4.6.b. Fellows must demonstrate knowledge of the basic science of wound healing, surgical anatomy, local and regional anesthesia, proper surgical technique, and, pre- and post-operative management of patients who undergo Mohs or cutaneous surgery. (Core)

4.6.c. Fellows must demonstrate knowledge of non-surgical treatments for cutaneous malignancies, non-surgical therapies for the prevention of cutaneous malignancies, and when surgical treatment is not the optimal primary therapy for a patient with a cutaneous malignancy. (Core)

4.6.d. Fellows must demonstrate knowledge of cutaneous metastatic disease from primary skin cancers and non-cutaneous malignancies, to include appropriate diagnostic evaluation, surgical management, and when referral to other specialists is appropriate. (Core)

[See FAQ in Appendix]

4.6.e. Fellows must demonstrate in-depth knowledge of clinical diagnosis, biology, and pathology of skin tumors, as well as laboratory interpretation related to diagnosis and surgical treatment. (Core)

4.7. ACGME Competencies – 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 lifelong learning. (Core)

4.8. ACGME Competencies – 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. (Core)

4.9. ACGME Competencies – Systems-Based Practice

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as

well as the ability to call effectively on other resources to provide optimal health care. (Core)

Curriculum Organization and Fellow Experiences

4.10. Curriculum Structure

The curriculum must be structured to optimize fellow educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)

4.10.a. Assignment of rotations must be structured to minimize the frequency of rotational transitions, and rotations must be of sufficient length to provide a quality educational experience defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and high-quality assessment and feedback. (Core)

4.10.b. Clinical experiences should be structured to facilitate learning in a manner that allows the fellows to function as part of an effective interprofessional team that works together longitudinally with shared goals of patient safety and quality improvement. (Core)

4.10.c. Maintenance of skills in the primary specialty or other aspects of procedural dermatology beyond micrographic surgery and dermatologic oncology should be limited to one half-day per week. (Core)

4.11. Didactic and Clinical Experiences

Fellows must be provided with protected time to participate in core didactic activities. (Core)

4.11.a. The program must provide an organized, systematic, and progressive educational experience that includes both clinical and didactic exposure for physicians seeking to acquire advanced competence as dermatologic surgeons. (Core)

4.11.b. There must be didactic sessions centered around a structured curriculum, to include a regularly-held journal club. (Core)

4.11.c. Didactic sessions should include regularly scheduled and held lectures, tutorials, seminars, multidisciplinary conferences, and conferences that consider complications, outcomes, and utilization review. (Detail)

4.11.d. Didactics must include participation by the fellow in a multidisciplinary tumor board for presentation of patients with advanced or aggressive cutaneous malignancies. (Core)

4.11.e. Programs must provide organized education and experience in all current aspects of micrographic surgery and dermatologic oncology. (Core)

4.11.e.1. This must include instruction and experience in Mohs micrographic surgery, and reconstruction of resultant surgical defects in a variety of anatomic locations using a variety of methods, to include complex cutaneous closures, local flaps, grafts, and staged reconstruction techniques. (Core)

4.11.e.2. This must include instruction and experience in non-surgical alternative treatments for cutaneous malignancies, such as cryosurgery, curettage and electrosurgery, chemical destructive techniques, and laser and light modalities. (Core)

4.11.e.3. This must include instruction in procedures of an aesthetic nature, including cutaneous soft tissue augmentation with injectable filler material, dermabrasion, skin resurfacing and tightening techniques, and laser procedures used to improve aesthetic appearance following cutaneous oncologic surgery. (Core)

4.11.e.3.a. Instruction in these procedures must provide fellows with the ability to properly assess the value of these techniques, as well as those of new techniques used to enhance restoration of the skins normal appearance and function. (Core)

4.11.f. The program must provide each fellow with formal education in setting up and operating a frozen section laboratory capable of processing sections for Mohs micrographic surgery. (Core)

4.11.f.1. The program must provide training and experience in supervising and training laboratory personnel. (Core)

4.11.g. Fellows must have experience working with health care personnel from dermatology, dermatopathology, and medical oncology. (Core)

4.11.h. Fellows must have experience in radiation oncology to ensure an ability to effectively work with other specialties essential to the optimal management of cutaneous oncology patients. (Core)

[See FAQ in Appendix]

4.11.i. Fellows must be actively engaged in teaching. (Core)

4.11.j. Fellow experience should also include interaction with general surgery, ophthalmology, otolaryngology, plastic surgery, and radiation oncology to ensure a broad knowledge of specialties essential to the optimal management of cutaneous malignancies. (Detail)

[See FAQ in Appendix]

4.11.k. Fellows must record all of their surgical cases in the ACGME Case Log System. (Core)

4.12. Pain Management

The program must provide instruction and experience in pain management if applicable for the subspecialty, including recognition of the signs of substance use disorder. (Core)

Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through fellow participation in scholarly activities as defined in the subspecialty-specific Program Requirements. Scholarly activities may include discovery, integration, application, and teaching.

The ACGME recognizes the variety of fellowships and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.

4.13. Program Responsibilities

The program must demonstrate evidence of scholarly activities, consistent with its mission(s) and aims. (Core)

4.13.a. The program must demonstrate evidence that the program director and core faculty members are engaged in scholarly activities, serving as role-models to the fellows. (Core)

4.14. Faculty Scholarly Activity

The program must demonstrate dissemination of scholarly activity within and external to the program through peer-reviewed publication, faculty members' participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or service as a journal reviewer, journal editorial board member, or editor. (Outcome)

4.15. Fellow Scholarly Activity

Each fellow must participate in scholarly activity by publishing or preparing one or more manuscripts suitable for submission to a peer-reviewed publication and/or giving at least one presentation at a regional or national professional society meeting on topics relevant to micrographic surgery and dermatologic oncology. (Outcome)

Section 5: Evaluation

5.1. Fellow Evaluation: Feedback and Evaluation

Faculty members must directly observe, evaluate, and frequently provide feedback on fellow performance during each rotation or similar educational assignment. (Core)

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower fellows to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring fellow learning* and providing ongoing feedback that can be used by fellows to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

- **fellows identify their strengths and weaknesses and target areas that need work**
- **program directors and faculty members recognize where fellows are struggling and address problems immediately**

Summative evaluation is *evaluating a fellow's learning* by comparing the fellows against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when fellows or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the fellowship program.

Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a new specialist to one with growing subspecialty expertise.

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Fellows require feedback from faculty members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for fellows who have deficiencies that may result in a poor final rotation evaluation.

5.1.a. Evaluation must be documented at the completion of the assignment. (Core)

5.1.a.1. Evaluations must be completed at least every three months. (Core)

5.1.b. The program must provide an objective performance evaluation based on the Competencies and the subspecialty-specific Milestones, and must: (Core)

5.1.b.1. use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)

5.1.b.2. provide that information to the Clinical Competency Committee for its synthesis of progressive fellow performance and improvement toward unsupervised practice. (Core)

Background and Intent: The trajectory to autonomous practice in a subspecialty is documented by the subspecialty-specific Milestones evaluation during fellowship. These Milestones detail the progress of a fellow in attaining skill in each competency domain. It is expected that the most growth in fellowship education occurs in patient care and medical knowledge, while the other four domains of competency must be ensured in the context of the subspecialty. They are developed by a subspecialty group and allow evaluation based on observable behaviors. The Milestones are considered formative and should be used to identify learning needs. This may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific fellow.

5.1.c. The program director or their designee, with input from the Clinical Competency Committee, must meet with and review with each fellow their documented semi-annual evaluation of performance, including progress along the subspecialty-specific Milestones. (Core)

5.1.d. The program director or their designee, with input from the Clinical Competency Committee, must develop plans for fellows failing to progress, following institutional policies and procedures. (Core)

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a fellow's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Fellows should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, fellows should develop an individualized learning plan.

Fellows who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the fellow, will take a variety of forms based on the specific learning needs of the fellow.

However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of fellow progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

5.1.e. **The evaluations of a fellow's performance must be accessible for review by the fellow.** (Core)

5.2. **Fellow Evaluation: Final Evaluation**

The program director must provide a final evaluation for each fellow upon completion of the program. (Core)

5.2.a. **The subspecialty-specific Milestones, and when applicable the subspecialty-specific Case Logs, must be used as tools to ensure fellows are able to engage in autonomous practice upon completion of the program.** (Core)

5.2.b. **The final evaluation must become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy.** (Core)

5.2.c. **The final evaluation must verify that the fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice.** (Core)

5.2.d. **The final evaluation must be shared with the fellow upon completion of the program.** (Core)

5.3. **Clinical Competency Committee**

A Clinical Competency Committee must be appointed by the program director. (Core)

[See FAQ in Appendix] [See FAQ in Appendix]

5.3.a. **At a minimum the Clinical Competency Committee must include three members, at least one of whom is a core faculty member. Members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows.** (Core)

Background and Intent: The requirements regarding the Clinical Competency Committee do not preclude or limit a program director's participation on the Clinical Competency Committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director's other roles as fellow advocate, advisor, and confidante; the impact of the program director's presence on the other Clinical Competency Committee members' discussions and decisions; the size of the program faculty; and other

program-relevant factors. The program director has final responsibility for fellow evaluation and promotion decisions.

The program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's fellows. There may be additional members of the Clinical Competency Committee.

[See FAQ in Appendix] [See FAQ in Appendix]

5.3.b. The Clinical Competency Committee must review all fellow evaluations at least semi-annually. (Core)

5.3.c. The Clinical Competency Committee must determine each fellow's progress on achievement of the subspecialty-specific Milestones. (Core)

5.3.d. The Clinical Competency Committee must meet prior to the fellows' semi-annual evaluations and advise the program director regarding each fellow's progress. (Core)

5.4. Faculty Evaluation

The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

Background and Intent: The program director is responsible for the educational program and for all educators. While the term "faculty" may be applied to physicians within a given institution for other reasons, it is applied to fellowship program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the fellow and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with fellows desire feedback on their education, clinical care, and research. If a faculty member does not interact with fellows, feedback is not required. With regard to the varied operating environments and configurations, the fellowship program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the fellows in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

5.4.a. **This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities.** (Core)

5.4.b. **This evaluation must include written, confidential evaluations by the fellows.** (Core)

5.4.c. **Faculty members must receive feedback on their evaluations at least annually.** (Core)

Background and Intent: The quality of the faculty's teaching and clinical care is a determinant of the quality of the program and the quality of the fellows' future clinical care. Therefore, the program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. This section mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

5.5. Program Evaluation and Improvement

The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)

5.5.a. **The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one fellow.** (Core)

5.5.b. **Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them.** (Core)

5.5.c. **Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes.** (Core)

5.5.d. **Program Evaluation Committee responsibilities must include review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.** (Core)

Background and Intent: To achieve its mission and educate and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of fellows and faculty members is a reflection of program quality, and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims.

The Program Evaluation Committee advises the program director through program oversight.

5.5.e. **The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate fellow and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)**

Background and Intent: Other data to be considered for assessment include:

- **Fellow performance**
- **Faculty development**
- **Progress on the previous year's action plan(s)**

5.5.f. **The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)**

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 5.5.f. has been suspended]

5.5.g. **The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the members of the teaching faculty and the fellows, and be submitted to the DIO. (Core)**

5.5.h. **The program must participate in a Self-Study and submit it to the DIO. (Core)**

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 5.5.h. has been suspended]

Board Certification

One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.

The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.

5.6. **Board Certification**

For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)

5.6.a. **For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty.** (Outcome)

5.6.b. **For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty.** (Outcome)

5.6.c. **For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty.** (Outcome)

5.6.d. **For each of the exams referenced in 5.6. – 5.6.c, any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that subspecialty.** (Outcome)

Background and Intent: Setting a single standard for pass rate that works across subspecialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are subspecialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and 5.6.d. is designed to address this.

5.6.e. **Programs must report, in ADS, board certification status annually for the cohort of board-eligible fellows that graduated seven years earlier.** (Core)

Background and Intent: It is essential that fellowship programs demonstrate knowledge and skill transfer to their fellows. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from fellowship graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

Section 6: The Learning and Working Environment

Fellowship education must occur in the context of a learning and working environment that emphasizes the following principles:

- ***Excellence in the safety and quality of care rendered to patients by fellows today***
- ***Excellence in the safety and quality of care rendered to patients by today's fellows in their future practice***
- ***Excellence in professionalism***
- ***Appreciation for the privilege of providing care for patients***
- ***Commitment to the well-being of the students, residents, fellows, faculty members, and all members of the health care team***

Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

6.1. The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

Patient Safety Events

Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

6.2. Residents, fellows, faculty members, and other clinical staff members must know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events. (Core)

6.2.a. Residents, fellows, faculty members, and other clinical staff members be provided with summary information of their institution's patient safety reports. (Core)

6.3. Fellows must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

Quality Metrics

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

6.4. Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)
[See FAQ in Appendix]

Supervision and Accountability

Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

6.5. Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)

6.5.a. This information must be available to fellows, faculty members, other members of the health care team, and patients. (Core)

Background and Intent: Each patient will have an identifiable and appropriately credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care.

6.6. The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous variability of fellow-patient interactions, training locations, and fellow skills and abilities, even at the same level of the educational program. The degree of supervision is expected to evolve progressively

as a fellow gains more experience, even with the same patient condition or procedure. The level of supervision for each fellow is commensurate with that fellow's level of independence in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious safety events, or other pertinent variables.

[See FAQ in Appendix]

Levels of Supervision

To promote appropriate fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision.

6.7. Direct Supervision

The supervising physician is physically present with the fellow during the key portions of the patient interaction.

[See FAQ in Appendix]

6.7.a. Physician faculty members must supervise fellows. (Core)

6.7.b. All fellows must have direct supervision available at all times. (Detail)

Indirect Supervision

The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the fellow for guidance and is available to provide appropriate direct supervision.

Oversight

The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

6.8. The program must define when physical presence of a supervising physician is required. (Core)

[See FAQ in Appendix]

6.9. 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)

6.9.a. The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones. (Core)

6.9.b. Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow. (Core)

6.9.c. **Fellows should serve in a supervisory role to junior fellows and 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)

6.10. **Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s).** (Core)

6.10.a. **Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence.** (Outcome)

> **Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.**

6.11. **Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each fellow and to delegate to the fellow the appropriate level of patient care authority and responsibility.** (Core)

6.12. **Professionalism**

Programs, in partnership with their Sponsoring Institutions, must educate fellows and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

> **Background and Intent: This requirement emphasizes the professional responsibility of fellows and faculty members to arrive for work adequately rested and ready to care for patients. It is also the responsibility of fellows, faculty members, and other members of the care team to be observant, to intervene, and/or to escalate their concern about fellow and faculty member fitness for work, depending on the situation, and in accordance with institutional policies. This includes recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team, and the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested practitioner.**

6.12.a. **The learning objectives of the program must be accomplished without excessive reliance on fellows to fulfill non-physician obligations.** (Core)

> **Background and Intent: Routine reliance on fellows to fulfill non-physician obligations increases work compression for fellows and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied**

health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that fellows may be expected to do any of these things on occasion when the need arises, these activities should not be performed by fellows routinely and must be kept to a minimum to optimize fellow education.

6.12.b. **The learning objectives of the program must ensure manageable patient care responsibilities.** (Core)

Background and Intent: The Common Program Requirements do not define "manageable patient care responsibilities" as this is variable by specialty/subspecialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty- and subspecialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty/subspecialty, should carefully assess how the assignment of patient care responsibilities can affect work compression.

6.12.c. **The learning objectives of the program must include efforts to enhance the meaning that each fellow finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships.** (Core)

6.12.d. **The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility.** (Core)

Background and Intent: The accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data are the responsibility of the program leadership, fellows, and faculty.

[See FAQ in Appendix]

6.12.e. **Fellows and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events.** (Core)
[See FAQ in Appendix]

6.12.f. **Programs, in partnership with their Sponsoring Institutions, must provide a professional, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, fellows, faculty, and staff.** (Core)

Background and Intent: Psychological safety is defined as an environment of trust and respect that allows individuals to feel able to ask for help, admit mistakes, raise concerns, suggest ideas, and challenge ways of working and the ideas of others on the team, including the ideas of those in authority, without fear of humiliation, and the knowledge that mistakes will be handled justly and fairly.

The ACGME is unable to adjudicate disputes between individuals, including residents, faculty members, and staff members. However, information that suggests a pattern of behavior that violates the requirement above will trigger a careful review and, if deemed appropriate, action by the Review Committee and/or ACGME, in accordance with ACGME Policies and Procedures.

6.12.g. Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

Well-Being

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of fellowship training.

Fellows and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares fellows with the skills and attitudes needed to thrive throughout their careers.

6.13. The responsibility of the program, in partnership with the Sponsoring Institution, must include:

6.13.a. attention to scheduling, work intensity, and work compression that impacts fellow well-being; (Core)

6.13.b. evaluating workplace safety data and addressing the safety of fellows and faculty members; (Core)

Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather informa-

tion and utilize systems that monitor and enhance fellow and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after safety events.

6.13.c. **policies and programs that encourage optimal fellow and faculty member well-being; and, (Core)**

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise. The intent of this requirement is to ensure that fellows have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Fellows must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

6.13.c.1. **Fellows must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)**

6.13.d. **education of fellows and faculty members in:**

6.13.d.1. **identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)**
[See FAQ in Appendix]

6.13.d.2. **recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)**

6.13.d.3. **access to appropriate tools for self-screening. (Core)**

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance use disorder. Materials and more information are available in Learn at ACGME (https://dl.acgme.org/pages/well-being-tools-resources).

Individuals experiencing burnout, depression, a substance use disorder, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and may be concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that fellows and faculty members are able to report their concerns when another fellow or faculty member displays signs of any of these conditions, so that the

program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Fellows and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness/well-being programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

6.13.e. **providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)**

Background and Intent: The intent of this requirement is to ensure that fellows have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement.

The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.

6.14. **There are circumstances in which fellows may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for fellows unable to perform their patient care responsibilities. (Core)**

6.14.a. **The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)**

6.14.b. **These policies must be implemented without fear of negative consequences for the fellow who is or was unable to provide the clinical work. (Core)**

Background and Intent: Fellows may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and fairly reintegrate them upon return.

6.15. **Fatigue Mitigation**

Programs must educate all fellows and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares fellows for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

6.16. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for fellows who may be too fatigued to safely return home. (Core)

6.17. Clinical Responsibilities

The clinical responsibilities for each fellow must be based on PGY level, patient safety, fellow ability, severity and complexity of patient illness/condition, and available support services. (Core)

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on fellows. Faculty members and program directors need to make sure fellows function in an environment that has safe patient care and a sense of fellow well-being. It is an essential responsibility of the program director to monitor fellow workload. Workload should be distributed among the fellow team and interdisciplinary teams to minimize work compression.

6.18. Teamwork

Fellows must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the subspecialty and larger health system. (Core)

Background and Intent: Effective programs will have a structure that promotes safe, interprofessional, team-based care. Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

6.18.a. Fellows must demonstrate the ability to work in an interprofessional team that includes clinic management, receptionists, nursing staff, histo-technicians, program faculty members, and referring clinical personnel. (Outcome)

6.18.a.1. Each fellow must be an integral part of the evaluation, management, and coordination of care of his or her surgical patients, and must demonstrate the ability to lead these interprofessional teams. (Outcome)

6.19. Transitions of Care

Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

[See FAQ in Appendix]

6.19.a. Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)

6.19.b. Programs must ensure that fellows are competent in communicating with team members in the hand-off process. (Outcome)

Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide fellows with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

Background and Intent: The terms "clinical experience and education," "clinical and educational work," and "clinical and educational work hours" replace the terms "duty hours," "duty periods," and "duty." These terms are used in response to concerns that the previous use of the term "duty" in reference to number of hours worked may have led some to conclude that fellows' duty to "clock out" on time superseded their duty to their patients.

6.20. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, including all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)

Background and Intent: Programs and fellows have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing fellows to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.

Work from Home

While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that fellows are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work fellows choose to do from home. The requirement provides flexibility for fellows to do this while ensuring that the time spent by fellows completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Fellow decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the fellow's supervisor. In such circumstances, fellows should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

Fellows are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual fellow. Programs will need to factor in time fellows are spending on clinical work at home when schedules are developed to ensure that fellows are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that fellows report their time from home and that schedules are structured to ensure that fellows are not working in excess of 80 hours per week, averaged over four weeks.

[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]

6.21. Mandatory Time Free of Clinical Work and Education

Fellows should have eight hours off between scheduled clinical work and education periods. (Detail)

Background and Intent: There may be circumstances when fellows choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This occurs within the context of the 80-hour and the one-day-off-in-seven requirements. While it is expected that fellow schedules will be structured to ensure that fellows are provided with a minimum of eight hours off between scheduled

work periods, it is recognized that fellows may choose to remain beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for fellows to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

6.21.a. Fellows must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)

Background and Intent: Fellows have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, fellows are encouraged to prioritize sleep over other discretionary activities.

[See FAQ in Appendix]

6.21.b. Fellows must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and fellow needs. It is strongly recommended that fellows' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some fellows may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide fellows with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes fellow well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."

[See FAQ in Appendix]

6.22. Maximum Clinical Work and Education Period Length

Clinical and educational work periods for fellows must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

6.22.a. Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or fellow education. Additional patient care responsibilities must not be assigned to a fellow during this time. (Core)

Background and Intent: The additional time referenced in 6.22.a. should not be used for the care of new patients. It is essential that the fellow continue to function as a member of the team in an environment where other members of the team can assess fellow fatigue, and that supervision for post-call fellows is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

[See FAQ in Appendix]

6.23. Clinical and Educational Work Hour Exceptions

In rare circumstances, after handing off all other responsibilities, a fellow, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)

6.23.a. These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)

Background and Intent: This requirement is intended to provide fellows with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a fellow may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Fellows must not be required to stay. Programs allowing fellows to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the fellow and that fellows are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

6.24. A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

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

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 6.24. has been suspended]

6.25. Moonlighting

Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program, and must not interfere with the fellow's fitness for work nor compromise patient safety. (Core)

[See FAQ in Appendix]

6.25.a. **Time spent by fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.** (Core)

6.26. **In-House Night Float**

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core)

6.27. **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). (Core)

6.28. **At-Home Call**

Time spent on patient care activities by fellows on at-home call must count toward the 80-hour maximum weekly 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 clinical work and education, when averaged over four weeks. (Core)

[See FAQ in Appendix] [See FAQ in Appendix]

6.28.a. **At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow.** (Core)

Background and Intent: As noted in 6.20., clinical work done from home when a fellow is taking at-home call must count toward the 80-hour maximum weekly limit. This acknowledges the often significant amount of time fellows devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in fellows routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

In their evaluation of fellowship programs, Review Committees will look at the overall impact of at-home call on fellow rest and personal time.

[See FAQ in Appendix]

7. Frequently Asked Questions: Micrographic Surgery and Dermatologic Oncology

FAQs related to Micrographic Surgery and Dermatologic Oncology Program Requirements

Last updated July 2026

Review Committee for Dermatology

Section 1: Oversight

Questions concerning *"There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)"* (1.3)

Q: What is the purpose of program letters of agreement (PLAs)?

A: PLAs provide details on faculty members, supervision, evaluation, educational content, length of assignment, and policies and procedures for each required assignment that occurs outside of an accredited program's Sponsoring Institution. These documents are intended to protect the program's residents/fellows by ensuring an appropriate educational experience under adequate supervision.

Questions concerning *"There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)"* (1.3)

Q: Under what circumstances are PLAs required?

A: There must be PLAs between an accredited program and all participating sites to which residents/fellows rotate for required education or assignments. PLAs are not required for participating sites under the same governance as the program's Sponsoring Institution. PLAs are not required for elective rotations for individual residents and fellows, but programs and Sponsoring Institutions may determine if there are local expectations for a PLA or similar agreement.

Questions concerning *"There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)"* (1.3)

Q: Are PLAs necessary for "courses," such as the Armed Forces Institute of Pathology course or the Bellevue Hospital Toxicology Course?

A: These types of courses are not examples of participating sites, and therefore do not require PLAs.

Questions concerning *"There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)"* (1.3)

Q: Who should sign the PLAs?

A: It is the responsibility of the designated institutional official (DIO), in collaboration with the Graduate Medical Education Committee (GMEC) of the Sponsoring Institution, to establish and administer the local policies and procedures regarding PLAs and determine the individuals authorized to sign the PLAs.

Questions concerning *"Frozen section slides for Mohs micrographic surgery must be reviewed and approved, as part of an ongoing quality assurance process, by an appropriately qualified external organization or equivalent academic medical center's Quality Assessment and Control program that has experience reviewing the unique method of histology slide preparation required to perform Mohs surgery. (Core)"* (1.7.b)

Q: Is there a specific organization that the Review Committee considers acceptable to fulfill the requirement for an organization to review and approve frozen section slides for Mohs micrographic surgery?

A: If utilizing an equivalent academic medical center's Quality Assessment and Control program, there must be evidence of peer-review. Additionally, the following must be included in the evaluation (taken from the ACMS process and considered "acceptable" by the Review Committee for demonstration of compliance):

1. The peer reviewer should be a physician with experience reading Mohs frozen sections and interpreting maps, and preferably a fellowship-trained Mohs surgeon.
2. The reviewer should document slide quality, including:
    a. appropriate tissue thickness
    b. quality of staining
    c. completeness of epidermal edge
    d. completeness of processing without holes
    e. quality of cutting fat
    f. lack of artifact
3. The reviewer should interpret the accuracy of diagnostic pathology.
4. The reviewer should interpret the accuracy of mapping positive slides.
5. The reviewer should interpret the accuracy of interpretation of positive and negative slides.

Section 2: Personnel

Questions concerning *"Qualifications of the Program Director"* (2.4) , *"The program director must possess current certification in the subspecialty for which they are the program director by the American Board of Dermatology or by the American Osteopathic Board of Dermatology, or subspecialty qualifications that are acceptable to the Review Committee. (Core)"* (2.4.a)

Q: Are there circumstances in which a Sponsoring Institution, in partnership with its programs, is required to provide support and dedicated time that exceeds the minimum specified in the requirements?

A: The dedicated time and support requirements for ACGME activities specified in 2.4. and 2.4.a. for program leadership, 2.12.a. and 2.12.b. for program coordinators, and section 2.11. for those specialties that specify a minimum level of support for core faculty members, are minimum requirements, recognizing that, depending on the unique needs of the

program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program director, is also addressed in Institutional Requirements 2.2.-2.2.d. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty-/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program directors, core faculty members, and program coordinators to fulfill their program responsibilities effectively. If the Institutional Review Committee determines that support and dedicated time for one or more programs within a Sponsoring Institution is inadequate, it may issue a citation even if the minimum specified in the applicable specialty-/subspecialty-specific Program Requirements has been met.

Note that Review Committees may choose to specify minimum time and support for the program director only, or may specify minimum time and support that may be divided among the program director and one or more associate or assistant program directors. Questions regarding the requirements for a specific specialty should be directed to the Review Committee Executive Director.

Questions concerning *"This must include an ongoing clinical practice in micrographic surgery and dermatologic oncology that includes personal performance of key aspects of micrographic surgery and dermatologic oncology as the fellow observes. (Core) "* (2.4.e)

Q: What does ongoing clinical practice in micrographic surgery and dermatologic oncology entail?

A: The expectation is that the program directors continue to be the primary surgeon in at least some dermatologic surgical and Mohs cases while overseeing a micrographic surgery and dermatologic oncology program.

Section 3: Fellow Appointments

Questions concerning *"Eligibility Requirements – Fellowship Programs"* (3.2)

Q: Are individuals who have completed a combined residency program not accredited by the ACGME eligible for appointment to an ACGME-accredited fellowship program?

A: Effective July 1, 2025, the ACGME accredits combined programs. If each of the programs participating in the combined format was ACGME-accredited prior to July 1, 2025, residents enrolled in the combined program are eligible for transfer into another ACGME-accredited residency program and graduates of the program are eligible for appointment to an ACGME-accredited fellowship.

Questions concerning *" review and approval of the applicant's exceptional qualifications by the GMEC; and, (Core) "* (3.2.b.1.b)

Q: Why does the ACGME require the GMEC or a subcommittee of the GMEC to review and approve all candidates under the "exceptionally qualified applicant" exception?

A: The Review Committee sets the requirements, and the program determines if a candidate meets the stated criteria. Because the Review Committee does not review or approve the determination of an exceptionally qualified applicant, the ACGME relies on the Sponsoring Institution to provide oversight in the selection of exceptional candidates and monitoring of

their performance. The oversight need not be burdensome or intrusive; rather it provides an opportunity for the GMEC to collaborate with programs to ensure that these select candidates fulfill expectations for entry-level competence.

Section 4: Educational Program

Questions concerning *"Fellows must demonstrate competence in making decisions regarding patient treatment, including instances in which the patient prefers to be referred or would benefit from referral to a different specialty or to a multidisciplinary team. (Core) "* (4.4.a) , *"Fellows must demonstrate knowledge of cutaneous metastatic disease from primary skin cancers and non-cutaneous malignancies, to include appropriate diagnostic evaluation, surgical management, and when referral to other specialists is appropriate. (Core) "* (4.6.d)

Q: When should referral to different specialists be considered?

A: The Review Committee considers the following as potential (not absolute) examples of when to refer:

- for patients who prefer care by another specialist or who desire reconstruction in an alternative setting (general anesthesia, operating room)
- for patients with complex defects, especially those expected to involve underlying critical vascular, boney, or cartilaginous structures (e.g., facial nerve great vessels, parotid gland, globe of eye)
- for patients who are medically complex and who may have difficulty tolerating prolonged surgery in the Mohs/dermatology setting
- for patients who have defects in anatomic areas that would be difficult to revise by the Mohs surgeon if the surgical outcome is unfavorable
- for patients with advanced-stage cutaneous malignancies that require multispecialty care for optimal outcome

Questions concerning *"Fellows must have experience in radiation oncology to ensure an ability to effectively work with other specialties essential to the optimal management of cutaneous oncology patients. (Core) "* (4.11.h) , *"Fellow experience should also include interaction with general surgery, ophthalmology, otolaryngology, plastic surgery, and radiation oncology to ensure a broad knowledge of specialties essential to the optimal management of cutaneous malignancies. (Detail) "* (4.11.j)

Q: Must a fellow have physical interactions (e.g., be present at the same site) with medical and radiation oncology, or will telephonic interaction (e.g., communicating by phone) satisfy the requirements regarding fellow experience with these specialties?

A: The Committee has determined that phone conversations with specialists are, at times, important and facilitate timely and effective care for patients, but alone are insufficient to meet these requirements. Likewise, participating in a distant multidisciplinary tumor board conference where patients familiar to the fellow are never discussed also would fail to meet the spirit of the requirements. The best example of compliance would involve fellows participating in a multidisciplinary tumor board conference that included radiation, medical, and surgical oncologists, among other specialists listed in the requirements, with opportunities to dialogue with those specialists about the care of cutaneous oncology patients familiar to the fellow. While in-person discussions would be preferred, the Committee acknowledges that

many conferences may need to occur through virtual means. In cases where conferences do not represent all listed subspecialists in the requirements, it is the responsibility of the program director to fill any gaps and be prepared to describe and justify this plan. It is also the responsibility of the program director to ensure that fellows work with sufficiently complex patients who need multidisciplinary care. The Committee understands that the logistics of how a fellow interacts with other specialists will vary, and notes that it is important for participation of the fellows in multidisciplinary cutaneous oncology clinics, multidisciplinary conferences, electronic messaging, letters, phone calls, or other interactions with the care team in the course of care coordination and decision-making.

Section 5: Evaluation

Questions concerning *"Clinical Competency Committee"* (5.3)

Q: What is the role of the program director on the Clinical Competency Committee (CCC)?

A: The requirements regarding the CCC do not preclude or limit a program director's participation on the committee, however, programs should consult with Review Committee staff for any specialty or subspecialty-specific guidance. The intent is to leave flexibility for each program to decide the best structure for its own circumstances. Still, a program should consider: its program director's other roles as resident/fellow advocate, advisor, and confidante; the impact of the program director's presence on the other CCC members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for the program's evaluation and promotion decisions.

Questions concerning *"Clinical Competency Committee"* (5.3)

Q: What is the role of the program coordinator on the CCC?

A: Program coordinators play a critical role in their programs and may, through the program's resident/fellow evaluation system, provide valuable insight on resident/fellow performance in areas such as interpersonal and communication skills, teamwork, and professionalism. Further, the program coordinator may, at the program director's discretion, attend CCC meetings to support the activities of the CCC, such as collation of data on each resident/fellow, taking meeting minutes, recording decisions, and managing the submission of Milestones data to the ACGME. However, evaluation of resident/fellow competence related to the Milestones for patient care and medical knowledge is a vital responsibility of the CCC and these assessments should be made by individuals with background and experience in health care. Therefore, program coordinators, although they may administratively support the committee and take part in the 360 assessments of the residents/fellows, may not serve as voting members of the CCC.

Questions concerning *"At a minimum the Clinical Competency Committee must include three members, at least one of whom is a core faculty member. Members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows. (Core)"* (5.3.a)

Q: How can small programs have three program faculty members on the CCC?

A: The intent is to have enough members to broaden the input on each resident's/fellow's evaluation. Program faculty representation can include more than physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's

residents/fellows. For example, a fellowship may include faculty members from the affiliated residency program or from required rotations in other specialties.

Questions concerning *"At a minimum the Clinical Competency Committee must include three members, at least one of whom is a core faculty member. Members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows. (Core)"* (5.3.a)

Q: What role can program residents, including chief residents who have not completed the program, play on the CCC?

A: Program residents and chief residents in accredited years of the program may provide input to the CCC Chair and/or the program director, outside the context of CCC meetings, through the evaluation system. However, to ensure that residents' peers are not involved in promotion and graduation decisions, and that they are not involved in recommendations for remediation or disciplinary actions, these residents may not serve as CCC members or attend CCC meetings.

Section 6: The Learning and Working Environment

Questions concerning *"Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)"* (6.4)

Q: With regards to the requirement relating to provision of data to residents/fellows and faculty members on quality metrics and benchmarks related to their patient populations, is the expectation that individual data regarding clinical performance must be provided?

A: Providing individual, specialty-specific data is desirable, but not required. The requirement seeks to ensure that quality metrics used by the Sponsoring Institution are shared with residents/fellows and faculty members. Examples of metrics include, but are not limited to, those provided by the Hospital Consumer Assessment of Healthcare Providers and Systems, Centers for Medicaid and Medicare Services, Press Gainey, and National Surgical Quality Improvement Program.

Questions concerning *"The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)"* (6.6) , *"Direct Supervision"* (6.7) , *"The program must define when physical presence of a supervising physician is required. (Core)"* (6.8)

Q: How should the appropriate level of supervision be determined for each resident or fellow?

A: The assignment of progressive responsibility for patient care to residents and fellows is an essential component of graduate medical education and is necessary to prepare residents and fellows to be independent practitioners. While decisions regarding the appropriate level of supervision are made by the program director in consultation with the CCC, the Common Program Requirements provide a framework for the progression from direct supervision to oversight. The program director determines the level of supervision required for an individual resident or fellow both by assessing the abilities and competence of the resident/fellow and the needs of the individual patient. Therefore, the level of supervision required for a resident or fellow may vary based on the circumstances.

Questions concerning *" The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core) "* (6.12.d) , *" Fellows and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core) "* (6.12.e) , *"Moonlighting"* (6.25)

Q: In addition to the 80-hour maximum weekly limit, do all other clinical and educational work hour rules apply to moonlighting (maximum clinical and educational work period length, minimum time off between shifts, etc.)?

A: The hours spent moonlighting are counted toward the total hours worked for the week. No other clinical and educational work hour requirements apply, but the following requirements do:

- 6.25 “Moonlighting must not interfere with the ability of the resident/fellow to achieve the goals and objectives of the educational program, and must not interfere with the resident’s/fellow’s fitness for work nor compromise patient safety.”
- 6.12.d.-6.12.e.“The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. Residents/Fellows and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events.”

Questions concerning *" identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core) "* (6.13.d.1)

Q: Can residents/fellows be required to use vacation or sick time when attending appointments during scheduled working hours?

A: The requirements do not specify whether residents/fellows will be required to use vacation or sick time for medical, dental, and mental health appointments. Programs should comply with their institution’s policies regarding time off for such appointments.

The intent of this requirement is to ensure that residents and fellows are able to attend appointments as needed, and that their work schedule not prevent them from seeking care when they need it, including during scheduled call days.

Questions concerning *"Transitions of Care"* (6.19)

Q: What are the ACGME’s expectations regarding transitions of care, and how should programs and institutions monitor effective transitions of care and minimize the number of such transitions?

A: Transitions of care are critical elements in patient safety and must be organized such that complete and accurate clinical information on all involved patients is transmitted between the outgoing and incoming individuals and/or teams responsible for the specific patient or group of patients. Sponsoring Institutions and programs are expected to have a documented process in place for ensuring the effectiveness of transitions. Scheduling of on-call

assignments should be optimized to ensure a minimal number of transitions, and there should be documentation of the process involved in arriving at the final schedule. Specific schedules will depend upon various factors, including the size of the program, the acuity and quantity of the workload, and the level of resident/fellow education.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: What are the ACGME's expectations regarding monitoring of clinical and educational work hours for all accredited programs?

A: The ACGME requires that Sponsoring Institutions and programs monitor residents'/fellows' clinical and educational work hours, including work done from home (as applicable), to ensure they comply with the requirements, but does not specify how monitoring and tracking of clinical and educational work hours should be accomplished. The ACGME does not mandate a specific monitoring approach since the ideal approach should be tailored to each program and its Sponsoring Institution.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: Do the ACGME Common Program Requirements related to clinical and educational work hours apply to research activities?

A: The clinical and educational work hour requirements pertain to all required hours in the program (the only exceptions are reading and self-learning). When research is a formal part of the residency/fellowship and occurs during the accredited years of the program, research hours or any combination of research and patient care activities must comply with the weekly limit on hours and other pertinent clinical and educational work hour requirements.

When programs offer an additional research year that is not part of the accredited years, or when residents/fellows conduct research on their own time, making these hours identical to other personal pursuits, these hours do not count toward the limit on clinical and educational work hours. The combined hours spent on self-directed research and program-required activities should meet the test for a reasonably rested and alert resident/fellow when the resident/fellow participates in patient care.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: What is included in the definition of clinical and educational work hours under the requirement limiting them to 80 hours per week?

A: Clinical and educational work hours are defined as all clinical and academic activities related to the residency/fellowship program. This includes inpatient and outpatient clinical care, in-house call, short call, night float and day float, transfer of patient care, and administrative activities related to patient care, such as completing medical records, ordering and reviewing lab tests, and signing orders. For call from home, time devoted to clinical work done from home and time spent in the hospital after being called in to provide patient care count toward the 80-hour weekly limit. Types of work from home that must be counted include using an electronic health record and taking calls. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours.

Hours spent on activities that are required in the accreditation requirements, such as membership on a hospital committee, or that are accepted practice in residency/fellowship programs, such as residents'/fellows' participation in interviewing residency/fellowship candidates, must be included in the count of clinical and educational work hours.

Time residents and fellows devote to military commitments counts toward the 80-hour limit only if that time is spent providing patient care.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: If some of a program's residents/fellows attend a conference that requires travel, how should the hours be counted for clinical and educational work hour compliance?

A: If attendance at the conference is required by the program, or if the resident/fellow is a representative for the program (e.g., presenting a paper or poster), the hours should be included as clinical and educational work hours. Travel time and non-conference hours while away do not meet the definition of "clinical and educational work hours" in the ACGME requirements.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: Why do the requirements specify that clinical work done from home must count toward the 80-hour weekly maximum, averaged over four weeks?

A: The requirements acknowledge the changes in medicine, including electronic health records, and the increase in the amount of work residents and fellows choose to do from home. Resident/Fellow decisions to complete work at home should be made in consultation with the resident's/fellow's supervisor. In such circumstances, residents/fellows should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality. The requirement provides flexibility for residents/fellows to do this while ensuring that the time spent completing clinical work from home is accomplished within the 80-hour weekly maximum.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: How should the averaging of the clinical and educational work hour requirements (e.g., 80-hour weekly limit, one day free of clinical and educational work every week, and call no more frequently than every third night) be handled? For example, what should be done if a resident/fellow takes a vacation week?

A: Averaging must occur by rotation. This is done over one of the following: a four-week period; a one-month period (28-31 days); or the period of the rotation if it is shorter than four weeks. When rotations are shorter than four weeks in length, averaging must be made over these shorter assignments. This avoids heavy and light assignments being combined to achieve compliance.

If a resident/fellow takes vacation or other leave, the ACGME requires that vacation or leave days be omitted from the numerator and the denominator for calculating clinical and educational work hours, call frequency, or days off. The requirements do not permit a "rolling" average, because this may mask compliance problems by averaging across high and low clinical and educational work hour rotations. The rotation with the greatest hours

and frequency of call must comply with the common clinical and educational work hour requirements.

Questions concerning *" Fellows must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core) "* (6.21.a)

Q: If a post-call resident/fellow remains on site for up to four additional hours as described in the requirements, does the required 14-hour time-off period begin at the end of the scheduled 24-hour period, or when the resident/fellow leaves the hospital?

A: The 14-hour time-off period begins when the resident/fellow completes all required clinical and educational work, regardless of when the resident/fellow was scheduled to leave.

Questions concerning *" Fellows must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core) "* (6.21.b)

Q: Since the requirements state that residents/fellows must be provided with one day in seven free from all responsibilities, with one day defined as one continuous 24-hour period, how should programs interpret this requirement if the “day off” occurs after a resident’s/fellow’s on-call day?

A: The requirements specify a 24-hour day off. This day should ideally be a calendar day (i.e., the resident/fellow wakes up at home and has a whole day available). It is not permissible to have the day off regularly or frequently scheduled on a resident’s/fellow’s post-call day, but in smaller programs this may occasionally be necessary. Note that in this case, a resident/fellow would need to leave the hospital post-call early enough to allow for 24 hours off from clinical and educational work. Because call from home does not require a rest period, the day after home call may be used as a day off.

Questions concerning *" Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or fellow education. Additional patient care responsibilities must not be assigned to a fellow during this time. (Core) "* (6.22.a)

Q: What activities are permitted during the four hours allowed for activities related to patient safety and/or resident/fellow education?

A: Residents/fellows who have completed a 24-hour clinical and educational work period may spend up to an additional four hours on site to ensure an appropriate, effective, and safe transition of care (including rounds), to maintain continuity of patient care, and to participate in educational activities such as conferences. During this four-hour period, residents/fellows must not be permitted to participate in the care of new patients in any patient care setting; must not be assigned to outpatient clinics, including continuity clinics; and must not be assigned to participate in a new procedure, such as an elective scheduled surgery. Residents/fellows who have satisfactorily completed the transition of care may attend an educational conference that occurs during this four-hour period.

Questions concerning *"At-Home Call"* (6.28)

Q: Is it permissible for residents/fellows to take call from home for extended periods, such as a month?

A: No. The requirement for one day free every week prohibits being assigned home call for an entire month. Assignment of a partial month (more than six days but fewer than 28 days) is possible. However, keep in mind that call from home is appropriate if service intensity and frequency of being called is low. Program directors are expected to monitor the intensity and workload resulting from home call through periodic assessment of workload and intensity of in-house activities.

Questions concerning *"At-Home Call"* (6.28) , *" At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow. (Core) "* (6.28.a)

Q: Which requirements apply to time in the hospital after being called in from home call?

A: For call taken from home (home or pager call), the time a resident/fellow spends in the hospital after being called in counts toward the weekly clinical and educational work hour limit. The only other numeric clinical and educational work hour requirement that applies is the one day free of clinical and educational work every week that must be free of all patient care responsibilities, which includes at-home call. Program directors must monitor the intensity and workload resulting from at-home call through periodic assessment of the frequency of being called into the hospital, and the length and intensity of the in-house activities.

When residents/fellows assigned to at-home call return to the hospital to care for patients, a new time-off period is not initiated, and therefore the requirement for eight hours between shifts does not apply. The frequency and duration of clinical work done from home and time returning to the hospital must not preclude rest or reasonable personal time for residents/fellows.

Other

Q: Can the clinical and educational work hour requirements be relaxed over holidays or during other times when a hospital is short-staffed, during periods when some residents/fellows are ill or on leave, or when there is an unusually large patient census or demand for care?

A: The ACGME expects that clinical and educational work hours in any given four-week period comply with all applicable requirements. This includes months with holidays, during which institutions may have fewer staff members available. During the holiday period, scheduling for the rotation (generally four weeks or a month) must comply with the common and specialty-specific clinical and educational work hour requirements. Further, the schedule during the holidays themselves may not violate common clinical and educational work hour requirements (such as the requirement for adequate rest between clinical and educational work periods), or specialty-specific requirements.

Q: Where are the ACGME Resident/Fellow and Faculty Survey -Common Program Requirements Crosswalk documents located?

A: The crosswalk documents for the Resident/Fellow and Faculty Surveys can be found on the ACGME website here. These resources help programs, residents, fellows, and faculty understand and interpret their ACGME Resident/Fellow and Faculty Survey results by mapping ACGME survey questions to the corresponding Common Program Requirements.