Accreditation Council for
Graduate Medical Education

ACGME Program Requirements for Regional Anesthesiology and Acute Pain Medicine

Program Requirements for Graduate Medical Education in Regional Anesthesiology and Acute Pain Medicine

Introduction

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

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

Int.B. Definition and Scope of the Specialty

Regional anesthesiology and acute pain medicine focuses on the management of acute pain, including the complete peri-operative pain management of surgical and non-surgical patients with or without interventional modes of analgesia. Fellowship training should result in the development of expertise in the practice and theory of regional anesthesiology and acute pain medicine.

Specifically, the scope of this specialty includes:

Int.B.1. pre-operative evaluation and management of pain, including indications and contraindications for interventional pain management techniques;

Int.B.2. intra-operative application of regional anesthesia (with or without general anesthesia);

Int.B.3. post-operative application of regional analgesia in inpatients and outpatients;

Int.B.4. peri-operative multimodal acute pain management of surgical patients; and,

52
53 Int.B.5. acute pain management of non-surgical patients.
54
55 Int.C. The educational program in regional anesthesiology and acute pain medicine
56 must be 12 months in length. (Core)
57
58 **I. Institutions**
59
60 **I.A. Sponsoring Institution**
61
62 **One sponsoring institution must assume ultimate responsibility for the**
63 **program, as described in the Institutional Requirements, and this**
64 **responsibility extends to fellow assignments at all participating sites. (Core)***
65
66 **The sponsoring institution and the program must ensure that the program**
67 **director has sufficient protected time and financial support for his or her**
68 **educational and administrative responsibilities to the program. (Core)**
69
70 I.A.1. The Sponsoring Institution must sponsor an Accreditation Council for
71 Graduate Medical Education (ACGME)-accredited anesthesiology
72 residency. (Core)
73
74 I.A.2. There must be only one regional anesthesiology and acute pain medicine
75 program associated with a single anesthesiology residency program. (Core)
76
77 **I.B. Participating Sites**
78
79 **I.B.1. There must be a program letter of agreement (PLA) between the**
80 **program and each participating site providing a required**
81 **assignment. The PLA must be renewed at least every five years. (Core)**
82
83 **The PLA should:**
84
85 **I.B.1.a) identify the faculty who will assume both educational and**
86 **supervisory responsibilities for fellows; (Detail)**
87
88 **I.B.1.b) specify their responsibilities for teaching, supervision, and**
89 **formal evaluation of fellows, as specified later in this**
90 **document; (Detail)**
91
92 **I.B.1.c) specify the duration and content of the educational**
93 **experience; and, (Detail)**
94
95 **I.B.1.d) state the policies and procedures that will govern fellow**
96 **education during the assignment. (Detail)**
97
98 **I.B.2. The program director must submit any additions or deletions of**
99 **participating sites routinely providing an educational experience,**
100 **required for all fellows, of one month full time equivalent (FTE) or**
101 **more through the Accreditation Council for Graduate Medical**
102 **Education (ACGME) Accreditation Data System (ADS). (Core)**

103
104 **II. Program Personnel and Resources**
105
106 **II.A. Program Director**
107
108 **II.A.1. There must be a single program director with authority and**
109 **accountability for the operation of the program. The sponsoring**
110 **institution's GMEC must approve a change in program director.** (Core)
111
112 **II.A.1.a) The program director must submit this change to the ACGME**
113 **via the ADS.** (Core)
114
115 **II.A.2. Qualifications of the program director must include:**
116
117 **II.A.2.a) requisite specialty expertise and documented educational**
118 **and administrative experience acceptable to the Review**
119 **Committee;** (Core)
120
121 **II.A.2.b) current certification in the subspecialty by the American**
122 **Board of Anesthesiology, or subspecialty qualifications that**
123 **are acceptable to the Review Committee; and,** (Core)
124
125 **II.A.2.c) current medical licensure and appropriate medical staff**
126 **appointment.** (Core)
127
128 **II.A.3. The program director must administer and maintain an educational**
129 **environment conducive to educating the fellows in each of the**
130 **ACGME competency areas.** (Core)
131
132 **The program director must:**
133
134 **II.A.3.a) prepare and submit all information required and requested by**
135 **the ACGME;** (Core)
136
137 **II.A.3.b) be familiar with and oversee compliance with ACGME and**
138 **Review Committee policies and procedures as outlined in the**
139 **ACGME Manual of Policies and Procedures;** (Detail)
140
141 **II.A.3.c) obtain review and approval of the sponsoring institution's**
142 **GMEC/DIO before submitting information or requests to the**
143 **ACGME, including:** (Core)
144
145 **II.A.3.c).(1) all applications for ACGME accreditation of new**
146 **programs;** (Detail)
147
148 **II.A.3.c).(2) changes in fellow complement;** (Detail)
149
150 **II.A.3.c).(3) major changes in program structure or length of**
151 **training;** (Detail)
152
153 **II.A.3.c).(4) progress reports requested by the Review Committee;**

154 (Detail)
155
156 **II.A.3.c).(5)** **requests for increases or any change to fellow duty**
157 **hours;** **(Detail)**
158
159 **II.A.3.c).(6)** **voluntary withdrawals of ACGME-accredited**
160 **programs;** **(Detail)**
161
162 **II.A.3.c).(7)** **requests for appeal of an adverse action; and,** **(Detail)**
163
164 **II.A.3.c).(8)** **appeal presentations to a Board of Appeal or the**
165 **ACGME.** **(Detail)**
166
167 **II.A.3.d)** **obtain DIO review and co-signature on all program**
168 **application forms, as well as any correspondence or**
169 **document submitted to the ACGME that addresses:** **(Detail)**
170
171 **II.A.3.d).(1)** **program citations, and/or,** **(Detail)**
172
173 **II.A.3.d).(2)** **request for changes in the program that would have**
174 **significant impact, including financial, on the program**
175 **or institution.** **(Detail)**
176
177 **II.B.** **Faculty**
178
179 **II.B.1.** **There must be a sufficient number of faculty with documented**
180 **qualifications to instruct and supervise all fellows.** **(Core)**
181
182 **II.B.2.** **The faculty must devote sufficient time to the educational program**
183 **to fulfill their supervisory and teaching responsibilities and**
184 **demonstrate a strong interest in the education of fellows.** **(Core)**
185
186 **II.B.3.** **The physician faculty must have current certification in the**
187 **subspecialty by the American Board of Anesthesiology, or possess**
188 **qualifications judged acceptable to the Review Committee.** **(Core)**
189
190 II.B.3.a) There must be at least two faculty members, including the
191 program director, with expertise in regional anesthesiology and
192 acute pain medicine. (Core)
193
194 II.B.3.b) At each participating site there must be a ratio of at least one FTE
195 faculty member to two fellows. (Core)
196
197 **II.B.4.** **The physician faculty must possess current medical licensure and**
198 **appropriate medical staff appointment.** **(Core)**
199
200 II.B.5. The faculty must establish and maintain an environment of inquiry and
201 scholarship with an active research component. (Core)
202
203 II.B.5.a) The members of the faculty must regularly participate in organized
204 clinical discussions, rounds, journal clubs, and conferences. (Core)

205
206 II.B.5.b) Some members of the faculty should also demonstrate
207 scholarship by one or more of the following:
208
209 II.B.5.b).(1) peer-reviewed funding; (Detail)
210
211 II.B.5.b).(2) publication of original research or review articles in peer-
212 reviewed journals, or chapters in textbooks; (Detail)
213
214 II.B.5.b).(3) publication or presentation of case reports or clinical series
215 at local, regional, or national professional and scientific
216 society meetings; or, (Detail)
217
218 II.B.5.b).(4) participation in national committees or educational
219 organizations. (Detail)
220
221 II.B.5.c) Faculty members must encourage and support fellows' scholarly
222 activities. (Core)
223
224 **II.C. Other Program Personnel**
225
226 **The institution and the program must jointly ensure the availability of all**
227 **necessary professional, technical, and clerical personnel for the effective**
228 **administration of the program. (Core)**
229
230 **II.D. Resources**
231
232 **The institution and the program must jointly ensure the availability of**
233 **adequate resources for fellow education, as defined in the specialty**
234 **program requirements. (Core)**
235
236 II.D.1. Equipment required for the performance of a wide variety of regional
237 anesthesiology/analgesia techniques, including ultrasound and nerve
238 stimulators, must be available. Appropriate monitoring and life support
239 equipment must be immediately available when invasive procedures are
240 performed by program personnel. (Core)
241
242 II.D.2. The patient population should include patients with a wide variety of
243 clinical acute pain problems to allow fellows to develop broad clinical
244 skills and knowledge required for a specialist in regional anesthesiology
245 and acute pain medicine. (Detail)
246
247 **II.E. Medical Information Access**
248
249 **Fellows must have ready access to specialty-specific and other appropriate**
250 **reference material in print or electronic format. Electronic medical literature**
251 **databases with search capabilities should be available. (Detail)**
252
253 **III. Fellow Appointments**
254
255 **III.A. Eligibility Requirements – Fellowship Programs**

256
257 **All required clinical education for entry into ACGME-accredited fellowship
258 programs must be completed in an ACGME-accredited residency program,
259 or in an RCPSC-accredited or CFPC-accredited residency program located
260 in Canada.** (Core)
261
262 Prior to appointment in the program, fellows must have successfully completed
263 an ACGME-accredited residency in anesthesiology. (Core)
264
265 **III.A.1.** **Fellowship programs must receive verification of each entering
266 fellow's level of competency in the required field using ACGME or
267 CanMEDS Milestones assessments from the core residency
268 program.** (Core)
269
270 **III.A.2.** **Fellow Eligibility Exception**
271
272 **A Review Committee may grant the following exception to the
273 fellowship eligibility requirements:**
274
275 **An ACGME-accredited fellowship program may accept an
276 exceptionally qualified applicant**, who does not satisfy the
277 eligibility requirements listed in Sections III.A. and III.A.1., but who
278 does meet all of the following additional qualifications and
279 conditions:** (Core)
280
281 **III.A.2.a)** **Assessment by the program director and fellowship selection
282 committee of the applicant's suitability to enter the program,
283 based on prior training and review of the summative
284 evaluations of training in the core specialty; and** (Core)
285
286 **III.A.2.b)** **Review and approval of the applicant's exceptional
287 qualifications by the GMEC or a subcommittee of the GMEC;
288 and** (Core)
289
290 **III.A.2.c)** **Satisfactory completion of the United States Medical
291 Licensing Examination (USMLE) Steps 1, 2, and, if the
292 applicant is eligible, 3, and;** (Core)
293
294 **III.A.2.d)** **For an international graduate, verification of Educational
295 Commission for Foreign Medical Graduates (ECFMG)
296 certification; and,** (Core)
297
298 **III.A.2.e)** **Applicants accepted by this exception must complete
299 fellowship Milestones evaluation (for the purposes of
300 establishment of baseline performance by the Clinical
301 Competency Committee), conducted by the receiving
302 fellowship program within six weeks of matriculation. This
303 evaluation may be waived for an applicant who has
304 completed an ACGME International-accredited residency
305 based on the applicant's Milestones evaluation conducted at
306 the conclusion of the residency program.** (Core)

III.A.2.e).(1) **If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training.** **(Core)**

**** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, 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; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.**

III.A.3. **The Review Committee for** Anesthesiology **does allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A.** **(Core)**

III.B. **Number of Fellows**

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

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

III.B.2. The presence of other learners or staff members must not interfere with the appointed fellows' education. (Core)

IV. **Educational Program**

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

IV.A.1. **Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills and competencies to fellows and faculty at least annually, in either written or electronic form.** **(Core)**

IV.A.2. **ACGME Competencies**

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

IV.A.2.a) **Patient Care and Procedural Skills**

358
359 **IV.A.2.a).(1)** **Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows: (Outcome)**
363
364 IV.A.2.a).(1).(a) must demonstrate competence by following standards for patient care and established guidelines and procedures for patient safety, error reduction, and improved patient outcomes; (Outcome)
368
369 IV.A.2.a).(1).(b) must demonstrate the following competencies in regional anesthesiology: (outcome)
371
372 IV.A.2.a).(1).(b).(i) performance of pre-operative patient evaluation and optimization of clinical status; (Outcome)
375
376 IV.A.2.a).(1).(b).(ii) performance of a detailed neurologic history and physical examination with particular attention to pre-existing neurologic deficits and their impact on the anesthetic plan; (Outcome)
381
382 IV.A.2.a).(1).(b).(iii) rational selection of regional anesthesiology and/or post-operative analgesic techniques for specific clinical situations; (Outcome)
385
386 IV.A.2.a).(1).(b).(iii).(a) This must include regional techniques, multimodal analgesia, and opioid and non-opioid pharmacological management. (Core)
390
391 IV.A.2.a).(1).(b).(iv) selection of regional versus general anesthesia for various procedures and patients in regard to patient recovery, patient outcome, operating room efficiency, and cost of care; (Outcome)
396
397 IV.A.2.a).(1).(b).(v) management of inadequate operative regional anesthetic and post-operative analgesic techniques, including the use of supplemental blockade, alternate approaches, and pharmacological intervention; and, (Outcome)
403
404 IV.A.2.a).(1).(b).(vi) skills and knowledge necessary to perform and to effectively teach a wide range of advanced practice block techniques, achieving a high success and low complication rate. (Outcome)

409
410 IV.A.2.a).(1).(c) must demonstrate the following competencies in acute pain medicine: (Outcome)
411
412
413 IV.A.2.a).(1).(c).(i) understanding how the acute pain medicine service addresses:
414
415
416 IV.A.2.a).(1).(c).(i).(a) surgical regional anesthetic techniques (as placed by the operating room (OR) anesthesiologist); (Outcome)
417
418
419
420
421 IV.A.2.a).(1).(c).(i).(b) the peri-operative use of analgesic techniques by the acute pain medicine service; (Outcome)
422
423
424
425 IV.A.2.a).(1).(c).(i).(c) the peri-operative management of acute pain medicine intervention; (Outcome)
426
427
428
429 IV.A.2.a).(1).(c).(i).(d) the provision of acute pain medicine services directed toward the patient with chronic pain who is also experiencing acute pain; and, (Outcome)
430
431
432
433
434 IV.A.2.a).(1).(c).(i).(e) the provision of acute pain management to select non-surgical patients, such as those with sickle cell disease or other conditions known to cause acute pain. (Outcome)
435
436
437
438
439
440 IV.A.2.a).(1).(c).(ii) management of an acute pain medicine service. (Outcome)
441
442
443 IV.A.2.a).(1).(c).(ii).(a) Patient management should include multimodal analgesic techniques, such as neuraxial and peripheral nerve catheters, local anesthetic and opioid infusions, and non-opioid analgesic adjuvants. (Detail)
444
445
446
447
448
449
450 **IV.A.2.a).(2)** **Fellows must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Fellows: (Outcome)**
451
452
453
454
455 IV.A.2.a).(2).(a) must demonstrate competence in providing anesthesia and peri-operative pain management for patients undergoing orthopedic surgery; (Outcome)
456
457
458
459 IV.A.2.a).(2).(b) must demonstrate competence in providing

460 anesthesia and peri-operative pain management for
461 patients undergoing non-orthopaedic surgery that is
462 amenable to regional anesthesiology, including
463 neuraxial and peripheral nerve block; and, (Outcome)
464
465 IV.A.2.a).(2).(c) must demonstrate competence in bedside point of
466 care ultrasound for use in placement and
467 management of neuraxial and peripheral blocks.
468 (Outcome)
469
470 **IV.A.2.b) Medical Knowledge**
471
472 **Fellows must demonstrate knowledge of established and**
473 **evolving biomedical, clinical, epidemiological and social-**
474 **behavioral sciences, as well as the application of this**
475 **knowledge to patient care. Fellows: (Outcome)**
476
477 IV.A.2.b).(1) must demonstrate knowledge of anatomy and clinical
478 pharmacology, including: (Outcome)
479
480 IV.A.2.b).(1).(a) central neuraxial and peripheral nerve anatomy,
481 including: (Outcome)
482
483 IV.A.2.b).(1).(a).(i) anatomy of neural pathways; (Outcome)
484
485 IV.A.2.b).(1).(a).(ii) differences between motor and sensory
486 nerves; and, (Outcome)
487
488 IV.A.2.b).(1).(a).(iii) microanatomy of the nerve cell. (Outcome)
489
490 IV.A.2.b).(1).(b) local anesthetic pharmacology, including the:
491 (Outcome)
492
493 IV.A.2.b).(1).(b).(i) mechanism of action, physicochemical
494 properties, pharmacokinetics and
495 pharmacodynamics, and appropriate dosing
496 for single injection or continuous infusion;
497 (Outcome)
498
499 IV.A.2.b).(1).(b).(ii) selection and dose of local anesthetics as
500 indicated for specific surgical conditions and
501 in different age groups from infants to
502 adults; (Outcome)
503
504 IV.A.2.b).(1).(b).(iii) dosing, advantages, and disadvantages of
505 local anesthetic adjuvants; and, (Outcome)
506
507 IV.A.2.b).(1).(b).(iv) signs, symptoms, and treatment of local
508 anesthetic systemic toxicity or neurotoxicity
509 of local anesthetics. (Outcome)
510

IV.A.2.b).(1).(c) neuraxial opioids, including: (Outcome)

IV.A.2.b).(1).(c).(i) indications/contraindications, mechanism of action, physicochemical properties, effective dosing, and duration of action; (Outcome)

IV.A.2.b).(1).(c).(ii) complications and adverse effects, including related monitoring, prevention, and therapy; and, (Outcome)

IV.A.2.b).(1).(c).(iii) differentiation of intrathecal versus epidural administration relative to dose, effect, and adverse effects. (Outcome)

IV.A.2.b).(1).(d) systemic opioids, including: (Outcome)

IV.A.2.b).(1).(d).(i) pharmacokinetics of opioid analgesics, to include bioavailability, absorption, distribution, metabolism, and excretion; (Outcome)

IV.A.2.b).(1).(d).(ii) mechanism of action; (Outcome)

IV.A.2.b).(1).(d).(iii) chemical structure; (Outcome)

IV.A.2.b).(1).(d).(iv) mechanisms, uses, and contraindications for opioid agonists, opioid antagonists, mixed agents and (Outcome)

IV.A.2.b).(1).(d).(v) use of patient controlled analgesic systems; (Outcome)

IV.A.2.b).(1).(d).(vi) post-procedure analgesic management in the patient with chronic pain and/or opioid-induced hyperalgesia; and, (Outcome)

IV.A.2.b).(1).(d).(vii) management of acute or chronic pain in the opioid tolerant patient. (Outcome)

IV.A.2.b).(1).(e) non-opioid analgesics, including: (Outcome)

IV.A.2.b).(1).(e).(i) multimodal analgesia and its impact on recovery after surgery; and, (Outcome)

IV.A.2.b).(1).(e).(ii) pharmacology of acetaminophen, NSAIDs, COX-2 inhibitors, N-methyl-D-aspartic acid antagonists, α-2 agonists, and γ-aminobutyric acid-pentanoic agents and anticonvulsant drugs with respect to optimizing post-operative analgesia. (Outcome)

562 IV.A.2.b).(2) must demonstrate knowledge of regional anesthesia
563 techniques, including:
564
565 IV.A.2.b).(2).(a) nerve localization techniques, including: (Outcome)
566
567 IV.A.2.b).(2).(a).(i) principles, operation, advantages, and
568 limitations of the peripheral nerve stimulator
569 to localize and anesthetize peripheral
570 nerves; (Outcome)
571
572 IV.A.2.b).(2).(a).(ii) principles of paresthesia-seeking,
573 perivascular, or transvascular approaches
574 to nerve localization; and, (Outcome)
575
576 IV.A.2.b).(2).(a).(iii) principles, operation, advantages, safety
577 and limitations of ultrasound to localize and
578 anesthetize peripheral nerves. (Outcome)
579
580 IV.A.2.b).(2).(b) spinal anesthesia, including: (Outcome)
581
582 IV.A.2.b).(2).(b).(i) anatomy of the neuraxis; (Outcome)
583
584 IV.A.2.b).(2).(b).(ii) indications, contraindications, adverse
585 effects, complications, and management of
586 spinal anesthesia; (Outcome)
587
588 IV.A.2.b).(2).(b).(iii) cardiovascular and pulmonary physiologic
589 effects of spinal anesthesia; (Outcome)
590
591 IV.A.2.b).(2).(b).(iv) common mechanisms for failed spinal
592 anesthetics; (Outcome)
593
594 IV.A.2.b).(2).(b).(v) various local anesthetics for intrathecal use,
595 to include agents, dosage, surgical and total
596 duration of action, and adjuvants; (Outcome)
597
598 IV.A.2.b).(2).(b).(vi) factors affecting intensity, extent, and
599 duration of block, to include patient position,
600 dose, volume, and baricity of injectate;
601 (Outcome)
602
603 IV.A.2.b).(2).(b).(vii) dural puncture headache, to include
604 symptoms, etiology, risk factors, and
605 treatment; and, (Outcome)
606
607 IV.A.2.b).(2).(b).(viii) advantages and disadvantages of
608 continuous spinal anesthesia. (Outcome)
609
610 IV.A.2.b).(2).(c) epidural anesthesia (lumbar and thoracic),
611 including: (Outcome)
612

613 IV.A.2.b).(2).(c).(i) indications, contraindications, adverse
614 effects, complications, and management of
615 epidural anesthesia and analgesia; (Outcome)
616
617 IV.A.2.b).(2).(c).(ii) local anesthetics for epidural use, to include
618 agents, dosage, adjuvants, and duration of
619 action; (Outcome)
620
621 IV.A.2.b).(2).(c).(iii) spinal and epidural anesthesia differences
622 in reliability, latency, duration, and
623 segmental limitations; (Outcome)
624
625 IV.A.2.b).(2).(c).(iv) value and techniques of test dosing to
626 minimize complications of epidural
627 anesthesia and analgesia; (Outcome)
628
629 IV.A.2.b).(2).(c).(v) interpretation of the volume-segment
630 relationship and the effect of patient age, to
631 include extremes of age, pregnancy,
632 position, and site of injection on resultant
633 block; (Outcome)
634
635 IV.A.2.b).(2).(c).(vi) combined spinal-epidural anesthesia, to
636 include advantages/disadvantages, dose
637 requirements, complications, indications,
638 and contraindications; (Outcome)
639
640 IV.A.2.b).(2).(c).(vii) outcome benefits of thoracic epidural
641 analgesia for thoracic and abdominal
642 surgery and thoracic trauma; (Outcome)
643
644 IV.A.2.b).(2).(c).(viii) differentiation between thoracic epidural
645 anesthesia/analgesia and lumbar epidural
646 anesthesia/analgesia, to include
647 advantages/disadvantages, dose
648 requirements, complications, indications,
649 and contraindications; and, (Outcome)
650
651 IV.A.2.b).(2).(c).(ix) impact of antithrombotic and thrombolytic
652 medications on neuraxial and peripheral
653 anesthesia/analgesia with specific reference
654 to published guidelines. (Outcome)
655
656 IV.A.2.b).(2).(d) upper extremity nerve block, including: (Outcome)
657
658 IV.A.2.b).(2).(d).(i) anatomy and sonoanatomy of the brachial
659 plexus in relation to sensory and motor
660 innervation; (Outcome)
661
662 IV.A.2.b).(2).(d).(ii) local anesthetics for brachial plexus block,
663 to include agents, dose, duration of action,

664 and adjuvants; (Outcome)
665
666 IV.A.2.b).(2).(d).(iii) value and techniques of intravascular test
667 dosing to minimize local anesthetic systemic
668 toxicity associated with peripheral nerve
669 block; (Outcome)
670
671 IV.A.2.b).(2).(d).(iv) differentiation between the various brachial
672 plexus (or terminal nerve) block sites, to
673 include indications, contraindications,
674 advantages, disadvantages, complications,
675 and management specific to each; (Outcome)
676
677 IV.A.2.b).(2).(d).(v) indications and technique for cervical
678 plexus, suprascapular, or intercostobrachial
679 block as unique blocks or supplements to
680 brachial plexus block; and, (Outcome)
681
682 IV.A.2.b).(2).(d).(vi) technical and non-technical aspects unique
683 to brachial plexus perineural catheter
684 placement and management. (Outcome)
685
686 IV.A.2.b).(2).(e) lower extremity nerve block, including: (Outcome)
687
688 IV.A.2.b).(2).(e).(i) anatomy and sonoanatomy of the lower
689 extremity, to include sciatic, femoral, lateral
690 femoral cutaneous, and obturator nerves, as
691 well as the adductor canal and options for
692 saphenous nerve blockade; (Outcome)
693
694 IV.A.2.b).(2).(e).(ii) local anesthetics for lower extremity block,
695 to include agents, dose, duration of action,
696 and adjuvants; (Outcome)
697
698 IV.A.2.b).(2).(e).(iii) value and techniques of intravascular test
699 dosing to minimize local anesthetic systemic
700 toxicity associated with peripheral nerve
701 block; (Outcome)
702
703 IV.A.2.b).(2).(e).(iv) differentiation between the various
704 approaches to lower-extremity blockade, to
705 include indications/contraindications, side
706 effects, complications, and management
707 specific to each; and, (Outcome)
708
709 IV.A.2.b).(2).(e).(v) technical and non-technical aspects unique
710 to lower extremity perineural catheter
711 placement and management. (Outcome)
712
713 IV.A.2.b).(2).(f) truncal block, including: (Outcome)
714

715 IV.A.2.b).(2).(f).(i) anatomy for intercostal, paravertebral,
716 ilioinguinal-hypogastric, rectus sheath and
717 transversus abdominis plane blocks; (Outcome)
718
719 IV.A.2.b).(2).(f).(ii) local anesthetics for truncal blockade:
720 agents, dose, and duration of action; (Outcome)
721
722 IV.A.2.b).(2).(f).(iii) indications, contraindications, side effects,
723 complications, safety, and management of
724 truncal blockade; and, (Outcome)
725
726 IV.A.2.b).(2).(f).(iv) technical and non-technical aspects unique
727 to continuous truncal catheter placement
728 and management. (Outcome)
729
730 IV.A.2.b).(2).(g) intravenous regional anesthesia, including: (Outcome)
731
732 IV.A.2.b).(2).(g).(i) mechanism of action, indications,
733 contraindications, advantages and
734 disadvantages, adverse effects,
735 complications, and management of
736 intravenous regional anesthesia (IVRA);
737 and, (Outcome)
738
739 IV.A.2.b).(2).(g).(ii) agents used for IVRA, to include local
740 anesthetic choice, dosage, and use of
741 adjuvants. (Outcome)
742
743 IV.A.2.b).(2).(h) complications of regional anesthesiology and acute
744 pain medicine, including diagnosis and
745 management of: (Outcome)
746
747 IV.A.2.b).(2).(h).(i) hemorrhagic complications; (Outcome)
748
749 IV.A.2.b).(2).(h).(ii) infectious complications; (Outcome)
750
751 IV.A.2.b).(2).(h).(iii) neurological complications; (Outcome)
752
753 IV.A.2.b).(2).(h).(iii).(a) This knowledge must include the
754 interpretation of tests recommended
755 following plexus/nerve injury,
756 including electromyography, nerve
757 conduction studies, somatosensory
758 evoked potentials, and motor evoked
759 potentials. (Outcome)
760
761 IV.A.2.b).(2).(h).(iv) complications due to medicines, including
762 local anesthetic systemic toxicity and opioid-
763 induced respiratory depression; and, (Outcome)
764
765 IV.A.2.b).(2).(h).(v) other complications, including

766 pneumothorax. (Outcome)
767
768 **IV.A.2.c) Practice-based Learning and Improvement**
769
770 **Fellows are expected to develop skills and habits to be able**
771 **to meet the following goals:**
772
773 **IV.A.2.c).(1) systematically analyze practice using quality**
774 **improvement methods, and implement changes with**
775 **the goal of practice improvement;** (Outcome)
776
777 **IV.A.2.c).(2) locate, appraise, and assimilate evidence from**
778 **scientific studies related to their patients' health**
779 **problems; (Outcome)**
780
781 IV.A.2.c).(3) identify strengths, deficiencies, and limits in knowledge and
782 expertise; (Outcome)
783
784 IV.A.2.c).(4) set learning and practice improvement goals; (Outcome)
785
786 IV.A.2.c).(5) identify and perform appropriate learning activities,
787 including didactic lectures and hands-on demonstrations
788 that promulgate safety; (Outcome)
789
790 IV.A.2.c).(6) incorporate formative evaluation feedback into daily
791 practice; (Outcome)
792
793 IV.A.2.c).(7) evaluate and apply evidence from scientific studies, expert
794 guidelines, and practice pathways to patients' medical
795 conditions; (Outcome)
796
797 IV.A.2.c).(8) apply information technology to obtain and record patient
798 information, access institutional and national policies and
799 guidelines, and participate in self education; (Outcome)
800
801 IV.A.2.c).(9) analyze their own practice with respect to patient outcomes
802 (especially success and complications from regional
803 blockade) and compare to available literature; (Outcome)
804
805 IV.A.2.c).(10) participate in the education of patients, families, students,
806 fellows, and other health care professionals; and, (Outcome)
807
808 IV.A.2.c).(11) advocate for acute pain management and create best
809 practices for pain management regarding major surgical
810 procedures. (Outcome)
811
812 **IV.A.2.d) Interpersonal and Communication Skills**
813
814 **Fellows must demonstrate interpersonal and communication**
815 **skills that result in the effective exchange of information and**
816 **collaboration with patients, their families, and health**

817 **professionals.** **(Outcome)**
818
819 Fellows are expected to demonstrate the ability to:
820
821 IV.A.2.d).(1) summarize information to the patient and family with
822 respect to the options, alternatives, risks, and benefits of
823 regional anesthesia and/or acute analgesic techniques in a
824 manner that is clear, understandable, and ethical; (Outcome)
825
826 IV.A.2.d).(2) develop effective listening skills and answer questions
827 appropriately in the process of obtaining informed consent;
828 and, (Outcome)
829
830 IV.A.2.d).(3) operate effectively in a team environment, communicating
831 and cooperating with surgeons, other physicians, nurses,
832 pharmacists, physical therapists, and other members of the
833 peri-operative team, including: (Outcome)
834
835 IV.A.2.d).(3).(a) recognizing the roles of all team members; (Outcome)
836
837 IV.A.2.d).(3).(b) communicating clearly in a professional manner
838 that facilitates the achievement of care goals;
839 (Outcome)
840
841 IV.A.2.d).(3).(c) helping other members of the team to enhance the
842 sharing of important information; and, (Outcome)
843
844 IV.A.2.d).(3).(d) formulating care plans that utilize multidisciplinary
845 team skills, such as a plan for facilitated recovery.
846 (Outcome)
847
848 **IV.A.2.e)** **Professionalism**
849
850 **Fellows must demonstrate a commitment to carrying out**
851 **professional responsibilities and an adherence to ethical**
852 **principles.** **(Outcome)**
853
854 Fellows are expected to demonstrate:
855
856 IV.A.2.e).(1) integrity, honesty, and accountability in conducting the
857 practice of medicine; (Outcome)
858
859 IV.A.2.e).(2) a commitment to life-long learning and excellence in
860 practice; (Outcome)
861
862 IV.A.2.e).(3) consistent subjugation of self-interest to the good of the
863 patient and the health care needs of society; and, (Outcome)
864
865 IV.A.2.e).(4) commitment to ethical principles in providing care,
866 obtaining informed consent, and maintaining patient
867 confidentiality. (Outcome)

868
869 **IV.A.2.f)** **Systems-based Practice**
870
871 **Fellows must demonstrate an awareness of and**
872 **responsiveness to the larger context and system of health**
873 **care, as well as the ability to call effectively on other**
874 **resources in the system to provide optimal health care.**
875 **(Outcome)**
876
877 Fellows are expected to:
878
879 IV.A.2.f).(1) effectively choose regional anesthesiology techniques and
880 approaches to promote peri-operative efficiency and
881 improve patient outcomes; (Outcome)
882
883 IV.A.2.f).(2) understand the interaction of the regional anesthesia and
884 acute pain medicine service with other elements of the
885 health care system, including primary surgical and medical
886 teams, and other consultant, nursing, pharmacy, and
887 physical therapy services; (Outcome)
888
889 IV.A.2.f).(3) demonstrate awareness of health care costs and resource
890 allocation, and the impact of their choices on those costs
891 and resources; (Outcome)
892
893 IV.A.2.f).(4) advocate for patients and their families within the health
894 care system, and assist them in understanding and
895 negotiating complexities in the system; (Outcome)
896
897 IV.A.2.f).(5) provide direct acute pain management and medical
898 consultation for the full spectrum of injuries, medical
899 etiologies, and surgical and other invasive procedures that
900 produce acute pain in the hospital setting; (Outcome)
901
902 IV.A.2.f).(6) when indicated, safely and effectively perform a
903 comprehensive range of advanced regional anesthesiology
904 procedures for appropriate indications, in a safe,
905 consistent, and reliable manner, understanding the
906 individual risks and benefits of each; (Outcome)
907
908 IV.A.2.f).(7) act as a consultant to other anesthesiologists, surgeons,
909 physicians, nurses, pharmacists, physical therapists and
910 other medical professionals, operating room managers,
911 hospital administrators, and other allied health providers;
912 (Outcome)
913
914 IV.A.2.f).(8) provide leadership in the organization and management of
915 an acute pain medicine service within the hospital setting,
916 comprising a variety of specialists to provide a
917 comprehensive, multimodal acute pain management
918 treatment plan; and, (Outcome)

919
920 IV.A.2.f).(9) develop the knowledge and skills required to establish a
921 new regional anesthesiology and acute pain medicine
922 program in his/her future practice, and to adopt emerging
923 knowledge and techniques for the acute pain management
924 of patients whom he/she encounters. (Outcome)
925
926 IV.A.3. Curriculum Organization and Fellow Experience
927
928 IV.A.3.a) The curriculum must include at least 10 months of clinical
929 anesthesiology experience, to include: (Core)
930
931 IV.A.3.a).(1) regional anesthesiology experience of at least six months,
932 including: (Core)
933
934 IV.A.3.a).(1).(a) a minimum of 20 spinal (intrathecal) procedures
935 either performed primarily or directly supervised by
936 the fellow, to include demonstration and
937 documentation of proficiency in using alternative
938 approaches (e.g., paramedian, epidural-assisted,
939 non-pencil point needle, and image-guided), difficult
940 and high-risk procedures, and rescue blocks where
941 others have failed; (Core)
942
943 IV.A.3.a).(1).(b) a minimum of 20 epidural procedures either
944 performed primarily or directly supervised by the
945 fellow, to include demonstration of proficiency in
946 thoracic epidural and with demonstration and
947 documentation of proficiency in using alternative
948 approaches (e.g., paramedian, spinal-needle
949 assisted, and image-guided), difficult and high-risk
950 procedures, and rescue blocks where others have
951 failed; (Core)
952
953 IV.A.3.a).(1).(c) a minimum of 100 upper extremity nerve block
954 procedures, to include demonstration of proficiency
955 in interscalene block, supraclavicular block,
956 infraclavicular block, and axillary block; (Core)
957
958 IV.A.3.a).(1).(d) a minimum of 100 lower extremity nerve block
959 procedures, to include demonstration of proficiency
960 in proximal sciatic block (e.g. gluteal and
961 subgluteal), popliteal sciatic block, femoral block,
962 adductor canal block, and ankle block; (Core)
963
964 IV.A.3.a).(1).(e) a minimum of 70 truncal block procedures, to
965 include demonstration of proficiency in transversus
966 abdominis plane block, rectus sheath block,
967 intercostal nerve block, and paravertebral block;
968 and, (Core)
969

970 IV.A.3.a).(1).(e).(i) Of these, a minimum of 20 must be
971 paravertebral block.(Core)
972
973 IV.A.3.a).(1).(f) a minimum of 50 continuous peripheral nerve block
974 catheter placement procedures, to include upper
975 and lower extremity and truncal sites. (Core)
976
977 IV.A.3.a).(2) acute pain experience of at least two months, including:
978 (Core)
979
980 IV.A.3.a).(2).(a) supervised assessment and management of
981 inpatients with acute pain; (Detail)
982
983 IV.A.3.a).(2).(b) management of epidural infusions, inpatient
984 continuous peripheral nerve infusions, ambulatory
985 continuous peripheral nerve infusions, and patient
986 controlled analgesia; (Detail)
987
988 IV.A.3.a).(2).(c) supervised assessment with specialized acute pain
989 considerations, to include concurrent anticoagulant
990 administration, chronic opioid use, neuromuscular
991 disorders, advanced age, and psychiatric disease;
992 and, (Detail)
993
994 IV.A.3.a).(2).(d) a minimum of 20 documented new patients for
995 each fellow. (Core)
996
997 IV.A.3.a).(3) chronic pain experience of at least two weeks, including
998 documented involvement with a minimum of 20 new
999 patients assessed in this setting; (Core)
1000
1001 IV.A.3.a).(3).(a) This experience must include supervised
1002 participation with pain medicine specialists
1003 responsible for the assessment and management
1004 of patients with chronic pain, including cancer
1005 pain.(Core)
1006
1007 IV.A.3.a).(3).(b) Patients should be seen through either consultation
1008 or while on a designated inpatient pain medicine
1009 service. (Detail)
1010
1011 IV.A.3.a).(4) pediatric experience; and, (Core)
1012
1013 IV.A.3.a).(4).(a) There should be experience with the age-
1014 appropriate assessment and treatment of acute
1015 pain in children including participation in acute pain
1016 management and regional anesthesia for pediatric
1017 surgical patients including infants, children, and
1018 adolescents (under 18 years). (Detail)
1019
1020 IV.A.3.a).(5) trauma experience (Core).

1021
1022 IV.A.3.a).(6) There should be experience with the assessment and
1023 treatment of acute pain in the setting of trauma. (Detail)
1024
1025 IV.A.3.b) There must be regularly scheduled didactic sessions. (Core)
1026
1027 IV.A.3.b).(1) The didactic curriculum should include lectures, peer-
1028 review case conferences, and/or morbidity and mortality
1029 conferences, as well as interdepartmental conferences or
1030 departmental grand rounds. (Detail)
1031
1032 IV.A.3.b).(1).(a) Subspecialty conferences, including review of all
1033 current complications and deaths, seminars, and
1034 clinical and basic science instruction, should be
1035 regularly conducted. (Detail)
1036
1037 IV.A.3.b).(1).(b) Fellows and faculty members must regularly attend
1038 program lectures, conferences, seminars, and
1039 workshops. (Core)
1040
1041 IV.A.3.b).(1).(c) Fellows should actively participate in the planning
1042 and production of these meetings. (Detail)
1043
1044 IV.A.3.b).(1).(c).(i) Faculty members should be the leaders in
1045 the majority of the sessions. (Detail)
1046
1047 IV.A.3.b).(1).(d) Multidisciplinary conferences must include
1048 participation from faculty members from regional
1049 anesthesiology, pain medicine, orthopaedic
1050 surgery, general surgery, obstetrics and
1051 gynecology, and pediatrics. (Core)
1052
1053 IV.A.3.b).(1).(d).(i) Fellows should attend a minimum of 10
1054 multidisciplinary conferences that are
1055 relevant to regional anesthesiology and
1056 acute pain medicine, especially in
1057 orthopaedic surgery and pain medicine.
1058 (Detail)
1059
1060 **IV.B. Fellows' Scholarly Activities**
1061
1062 IV.B.1. Academic Activities
1063
1064 IV.B.1.a) Fellows must participate in research as a major activity of the
1065 fellowship. (Core)
1066
1067 IV.B.1.b) To accomplish these objectives, the regional anesthesiology and
1068 acute pain medicine faculty must mentor the fellow in the
1069 preparation of research proposals, research methodology, and
1070 authorship guidelines. (Core)
1071

1072 IV.B.1.b).(1) Fellows should give research presentations at national or
1073 regional meetings. (Detail)
1074
1075 Fellows must:
1076
1077 IV.B.1.b).(2) engage in teaching activities as a major activity of the
1078 fellowship. (Core)
1079
1080 IV.B.1.b).(3) create and present a lecture during departmental or
1081 divisional grand rounds, or at a local/regional/national
1082 meeting, covering a topic, research, or a case relevant to
1083 regional anesthesia or acute pain medicine; (Core)
1084
1085 IV.B.1.b).(4) prepare and present resident education lectures and
1086 journal reviews for regional anesthesia and/or acute pain
1087 medicine subspecialty conferences; (Core)
1088
1089 IV.B.1.b).(5) participate and direct cadaver anatomy laboratories for
1090 regional anesthesia if available; (Core)
1091
1092 IV.B.1.b).(6) develop teaching techniques by instructing residents
1093 and/or medical students at the bedside with the
1094 supervision of faculty member(s); and, (Core)
1095
1096 IV.B.1.b).(7) review and enhance web-based teaching resources, such
1097 as resident teaching materials, curriculum documents, and
1098 self-study and testing materials. (Core)
1099
1100 **V. Evaluation**
1101
1102 **V.A. Fellow Evaluation**
1103
1104 **V.A.1. The program director must appoint the Clinical Competency**
1105 **Committee. (Core)**
1106
1107 **V.A.1.a) At a minimum the Clinical Competency Committee must be**
1108 **composed of three members of the program faculty. (Core)**
1109
1110 **V.A.1.a).(1) The program director may appoint additional members**
1111 **of the Clinical Competency Committee.**
1112
1113 **V.A.1.a).(1).(a) These additional members must be physician**
1114 **faculty members from the same program or**
1115 **other programs, or other health professionals**
1116 **who have extensive contact and experience**
1117 **with the program's fellows in patient care and**
1118 **other health care settings. (Core)**
1119
1120 **V.A.1.a).(1).(b) Chief residents who have completed core**
1121 **residency programs in their specialty and are**
1122 **eligible for specialty board certification may be**

1123 members of the Clinical Competency
1124 **Committee.** (Core)
1125
1126 **V.A.1.b)** **There must be a written description of the responsibilities of**
1127 **the Clinical Competency Committee.** (Core)
1128
1129 **V.A.1.b).(1)** **The Clinical Competency Committee should:**
1130
1131 **V.A.1.b).(1).(a)** **review all fellow evaluations semi-annually;** (Core)
1132
1133 **V.A.1.b).(1).(b)** **prepare and ensure the reporting of Milestones**
1134 **evaluations of each fellow semi-annually to**
1135 **ACGME; and,** (Core)
1136
1137 **V.A.1.b).(1).(c)** **advise the program director regarding fellow**
1138 **progress, including promotion, remediation,**
1139 **and dismissal.** (Detail)
1140
1141 **V.A.2.** **Formative Evaluation**
1142
1143 **V.A.2.a)** **The faculty must evaluate fellow performance in a timely**
1144 **manner.** (Core)
1145
1146 **V.A.2.b)** **The program must:**
1147
1148 **V.A.2.b).(1)** **provide objective assessments of competence in**
1149 **patient care and procedural skills, medical knowledge,**
1150 **practice-based learning and improvement,**
1151 **interpersonal and communication skills,**
1152 **professionalism, and systems-based practice based**
1153 **on the specialty-specific Milestones;** (Core)
1154
1155 V.A.2.b).(1).(a) These should include evaluations of interpersonal
1156 communication and relationship skills, fund of
1157 knowledge, manual skills, decision-making skills,
1158 and critical analysis of clinical situations. (Detail)
1159
1160 **V.A.2.b).(2)** **use multiple evaluators (e.g., faculty, peers, patients,**
1161 **self, and other professional staff); and,** (Detail)
1162
1163 **V.A.2.b).(3)** **provide each fellow with documented semiannual**
1164 **evaluation of performance with feedback.** (Core)
1165
1166 **V.A.2.c)** **The evaluations of fellow performance must be accessible for**
1167 **review by the fellow, in accordance with institutional policy.**
1168 (Detail)
1169
1170 **V.A.3.** **Summative Evaluation**
1171
1172 **V.A.3.a)** **The specialty-specific Milestones must be used as one of the**
1173 **tools to ensure fellows are able to practice core professional**

1174 activities without supervision upon completion of the
1175 program. (Core)
1176
1177 **V.A.3.b)** **The program director must provide a summative evaluation**
1178 **for each fellow upon completion of the program.** (Core)
1179
1180 **This evaluation must:**
1181
1182 **V.A.3.b).(1)** **become part of the fellow's permanent record**
1183 **maintained by the institution, and must be accessible**
1184 **for review by the fellow in accordance with**
1185 **institutional policy;** (Detail)
1186
1187 **V.A.3.b).(2)** **document the fellow's performance during their**
1188 **education; and,** (Detail)
1189
1190 **V.A.3.b).(3)** **verify that the fellow has demonstrated sufficient**
1191 **competence to enter practice without direct**
1192 **supervision.** (Detail)
1193
1194 **V.B.** **Faculty Evaluation**
1195
1196 **V.B.1.** **At least annually, the program must evaluate faculty performance as**
1197 **it relates to the educational program.** (Core)
1198
1199 **V.B.2.** **These evaluations should include a review of the faculty's clinical**
1200 **teaching abilities, commitment to the educational program, clinical**
1201 **knowledge, professionalism, and scholarly activities.** (Detail)
1202
1203 **V.C.** **Program Evaluation and Improvement**
1204
1205 **V.C.1.** **The program director must appoint the Program Evaluation**
1206 **Committee (PEC).** (Core)
1207
1208 **V.C.1.a)** **The Program Evaluation Committee:**
1209
1210 **V.C.1.a).(1)** **must be composed of at least two program faculty**
1211 **members and should include at least one fellow;** (Core)
1212
1213 **V.C.1.a).(2)** **must have a written description of its responsibilities;**
1214 **and,** (Core)
1215
1216 **V.C.1.a).(3)** **should participate actively in:**
1217
1218 **V.C.1.a).(3).(a)** **planning, developing, implementing, and**
1219 **evaluating educational activities of the**
1220 **program;** (Detail)
1221
1222 **V.C.1.a).(3).(b)** **reviewing and making recommendations for**
1223 **revision of competency-based curriculum goals**
1224 **and objectives;** (Detail)

1225
1226 **V.C.1.a).(3).(c)** **addressing areas of non-compliance with**
1227 **ACGME standards; and, (Detail)**
1228
1229 **V.C.1.a).(3).(d)** **reviewing the program annually using**
1230 **evaluations of faculty, fellows, and others, as**
1231 **specified below. (Detail)**
1232
1233 **V.C.2.** **The program, through the PEC, must document formal, systematic**
1234 **evaluation of the curriculum at least annually, and is responsible for**
1235 **rendering a written, annual program evaluation. (Core)**
1236
1237 **The program must monitor and track each of the following areas:**
1238
1239 **V.C.2.a)** **fellow performance; (Core)**
1240
1241 **V.C.2.b)** **faculty development; and, (Core)**
1242
1243 **V.C.2.c)** **progress on the previous year's action plan(s). (Core)**
1244
1245 **V.C.3.** **The PEC must prepare a written plan of action to document**
1246 **initiatives to improve performance in one or more of the areas listed**
1247 **in section V.C.2., as well as delineate how they will be measured and**
1248 **monitored. (Core)**
1249
1250 **V.C.3.a)** **The action plan should be reviewed and approved by the**
1251 **teaching faculty and documented in meeting minutes. (Detail)**
1252
1253 **VI. Fellow Duty Hours in the Learning and Working Environment**
1254
1255 **VI.A. Professionalism, Personal Responsibility, and Patient Safety**
1256
1257 **VI.A.1.** **Programs and sponsoring institutions must educate fellows and**
1258 **faculty members concerning the professional responsibilities of**
1259 **physicians to appear for duty appropriately rested and fit to provide**
1260 **the services required by their patients. (Core)**
1261
1262 **VI.A.2.** **The program must be committed to and responsible for promoting**
1263 **patient safety and fellow well-being in a supportive educational**
1264 **environment. (Core)**
1265
1266 **VI.A.3.** **The program director must ensure that fellows are integrated and**
1267 **actively participate in interdisciplinary clinical quality improvement**
1268 **and patient safety programs. (Core)**
1269
1270 **VI.A.4.** **The learning objectives of the program must:**
1271
1272 **VI.A.4.a)** **be accomplished through an appropriate blend of supervised**
1273 **patient care responsibilities, clinical teaching, and didactic**
1274 **educational events; and, (Core)**
1275

1276 **VI.A.4.b)** **not be compromised by excessive reliance on fellows to fulfill**
1277 **non-physician service obligations.** **(Core)**
1278
1279 **VI.A.5.** **The program director and sponsoring institution must ensure a**
1280 **culture of professionalism that supports patient safety and personal**
1281 **responsibility.** **(Core)**
1282
1283 **VI.A.6.** **Fellows and faculty members must demonstrate an understanding**
1284 **and acceptance of their personal role in the following:**
1285
1286 **VI.A.6.a)** **assurance of the safety and welfare of patients entrusted to**
1287 **their care;** **(Outcome)**
1288
1289 **VI.A.6.b)** **provision of patient- and family-centered care;** **(Outcome)**
1290
1291 **VI.A.6.c)** **assurance of their fitness for duty;** **(Outcome)**
1292
1293 **VI.A.6.d)** **management of their time before, during, and after clinical**
1294 **assignments;** **(Outcome)**
1295
1296 **VI.A.6.e)** **recognition of impairment, including illness and fatigue, in**
1297 **themselves and in their peers;** **(Outcome)**
1298
1299 **VI.A.6.f)** **attention to lifelong learning;** **(Outcome)**
1300
1301 **VI.A.6.g)** **the monitoring of their patient care performance improvement**
1302 **indicators; and,** **(Outcome)**
1303
1304 **VI.A.6.h)** **honest and accurate reporting of duty hours, patient**
1305 **outcomes, and clinical experience data.** **(Outcome)**
1306
1307 **VI.A.7.** **All fellows and faculty members must demonstrate responsiveness**
1308 **to patient needs that supersedes self-interest. They must recognize**
1309 **that under certain circumstances, the best interests of the patient**
1310 **may be served by transitioning that patient's care to another**
1311 **qualified and rested provider.** **(Outcome)**
1312
1313 **VI.B.** **Transitions of Care**
1314
1315 **VI.B.1.** **Programs must design clinical assignments to minimize the number**
1316 **of transitions in patient care.** **(Core)**
1317
1318 **VI.B.2.** **Sponsoring institutions and programs must ensure and monitor**
1319 **effective, structured hand-over processes to facilitate both**
1320 **continuity of care and patient safety.** **(Core)**
1321
1322 **VI.B.3.** **Programs must ensure that fellows are competent in communicating**
1323 **with team members in the hand-over process.** **(Outcome)**
1324
1325 **VI.B.4.** **The sponsoring institution must ensure the availability of schedules**
1326 **that inform all members of the health care team of attending**

1327 **physicians and fellows currently responsible for each patient's care.**
1328 **(Detail)**
1329
1330 **VI.C. Alertness Management/Fatigue Mitigation**
1331
1332 **VI.C.1. The program must:**
1333
1334 **VI.C.1.a) educate all faculty members and fellows to recognize the**
1335 **signs of fatigue and sleep deprivation; (Core)**
1336
1337 **VI.C.1.b) educate all faculty members and fellows in alertness**
1338 **management and fatigue mitigation processes; and, (Core)**
1339
1340 **VI.C.1.c) adopt fatigue mitigation processes to manage the potential**
1341 **negative effects of fatigue on patient care and learning, such**
1342 **as naps or back-up call schedules. (Detail)**
1343
1344 **VI.C.2. Each program must have a process to ensure continuity of patient**
1345 **care in the event that a fellow may be unable to perform his/her**
1346 **patient care duties. (Core)**
1347
1348 **VI.C.3. The sponsoring institution must provide adequate sleep facilities**
1349 **and/or safe transportation options for fellows who may be too**
1350 **fatigued to safely return home. (Core)**
1351
1352 **VI.D. Supervision of Fellows**
1353
1354 **VI.D.1. In the clinical learning environment, each patient must have an**
1355 **identifiable, appropriately-credentialed and privileged attending**
1356 **physician (or licensed independent practitioner as approved by each**
1357 **Review Committee) who is ultimately responsible for that patient's**
1358 **care. (Core)**
1359
1360 **VI.D.1.a) This information should be available to fellows, faculty**
1361 **members, and patients. (Detail)**
1362
1363 **VI.D.1.b) Fellows and faculty members should inform patients of their**
1364 **respective roles in each patient's care. (Detail)**
1365
1366 **VI.D.2. The program must demonstrate that the appropriate level of**
1367 **supervision is in place for all fellows who care for patients. (Core)**
1368
1369 **Supervision may be exercised through a variety of methods. Some**
1370 **activities require the physical presence of the supervising faculty**
1371 **member. For many aspects of patient care, the supervising**
1372 **physician may be a more advanced fellow. Other portions of care**
1373 **provided by the fellow can be adequately supervised by the**
1374 **immediate availability of the supervising faculty member or fellow**
1375 **physician, either in the institution, or by means of telephonic and/or**
1376 **electronic modalities. In some circumstances, supervision may**
1377 **include post-hoc review of fellow-delivered care with feedback as to**

1378 **the appropriateness of that care.** (Detail)
1379
1380 **VI.D.3.** **Levels of Supervision**
1381
1382 **To ensure oversight of fellow supervision and graded authority and**
1383 **responsibility, the program must use the following classification of**
1384 **supervision:** (Core)
1385
1386 **VI.D.3.a)** **Direct Supervision – the supervising physician is physically**
1387 **present with the fellow and patient.** (Core)
1388
1389 **VI.D.3.b)** **Indirect Supervision:**
1390
1391 **VI.D.3.b).(1)** **with direct supervision immediately available – the**
1392 **supervising physician is physically within the hospital**
1393 **or other site of patient care, and is immediately**
1394 **available to provide Direct Supervision.** (Core)
1395
1396 **VI.D.3.b).(2)** **with direct supervision available – the supervising**
1397 **physician is not physically present within the hospital**
1398 **or other site of patient care, but is immediately**
1399 **available by means of telephonic and/or electronic**
1400 **modalities, and is available to provide Direct**
1401 **Supervision.** (Core)
1402
1403 **VI.D.3.c)** **Oversight – the supervising physician is available to provide**
1404 **review of procedures/encounters with feedback provided**
1405 **after care is delivered.** (Core)
1406
1407 **VI.D.4.** **The privilege of progressive authority and responsibility, conditional**
1408 **independence, and a supervisory role in patient care delegated to**
1409 **each fellow must be assigned by the program director and faculty**
1410 **members.** (Core)
1411
1412 **VI.D.4.a)** **The program director must evaluate each fellow's abilities**
1413 **based on specific criteria. When available, evaluation should**
1414 **be guided by specific national standards-based criteria.** (Core)
1415
1416 **VI.D.4.b)** **Faculty members functioning as supervising physicians**
1417 **should delegate portions of care to fellows, based on the**
1418 **needs of the patient and the skills of the fellows.** (Detail)
1419
1420 **VI.D.4.c)** **Fellows should serve in a supervisory role of residents or**
1421 **junior fellows in recognition of their progress toward**
1422 **independence, based on the needs of each patient and the**
1423 **skills of the individual fellow.** (Detail)
1424
1425 **VI.D.5.** **Programs must set guidelines for circumstances and events in**
1426 **which fellows must communicate with appropriate supervising**
1427 **faculty members, such as the transfer of a patient to an intensive**
1428 **care unit, or end-of-life decisions.** (Core)

1429
1430 **VI.D.5.a)** **Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.** (Outcome)
1431
1432
1433
1434 **VI.D.6.** **Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility.** (Detail)
1435
1436
1437
1438
1439 **VI.E. Clinical Responsibilities**
1440
1441 **The clinical responsibilities for each fellow must be based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services.** (Core)
1442
1443
1444
1445 VI.E.1. An optimal clinical workload allows fellows to complete the required case numbers and develop the required competencies in patient care with a focus on learning over meeting service obligations. (Detail)
1446
1447
1448
1449 **VI.F. Teamwork**
1450
1451 **Fellows must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.** (Core)
1452
1453
1454
1455
1456 VI.F.1. Fellows should demonstrate leadership in the coordination of patient care, with teams that may include surgeons, anesthesiology colleagues, other medical trainees, specialized advanced practice nurses, physician assistants, and medical subspecialists such as neurologists, intensivists, and chronic pain specialists. (Detail)
1457
1458
1459
1460
1461
1462 VI.F.2. Fellows should understand the effective deployment of interprofessional teams that may include non-physician health care professionals, such as advanced practice nurses, physician assistants, pharmacists, physical therapists, specialized nurses, and technicians in order to provide high-quality, cost-effective patient care. (Detail)
1463
1464
1465
1466
1467
1468 **VI.G. Fellow Duty Hours**
1469
1470 **VI.G.1. Maximum Hours of Work per Week**
1471
1472 **Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.** (Core)
1473
1474
1475
1476 **VI.G.1.a) Duty Hour Exceptions**
1477
1478 **A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a**
1479

1480 **sound educational rationale.** **(Detail)**
1481
1482 The Review Committee for Anesthesiology will not consider
1483 requests for exceptions to the 80-hour limit to the residents' work
1484 week.
1485
1486 **VI.G.1.a).(1)** **In preparing a request for an exception the program**
1487 **director must follow the duty hour exception policy**
1488 **from the ACGME Manual on Policies and Procedures.**
1489 **(Detail)**
1490
1491 **VI.G.1.a).(2)** **Prior to submitting the request to the Review**
1492 **Committee, the program director must obtain approval**
1493 **of the institution's GMEC and DIO.** **(Detail)**
1494
1495 **VI.G.2.** **Moonlighting**
1496
1497 **VI.G.2.a)** **Moonlighting must not interfere with the ability of the fellow**
1498 **to achieve the goals and objectives of the educational**
1499 **program.** **(Core)**
1500
1501 **VI.G.2.b)** **Time spent by fellows in Internal and External Moonlighting**
1502 **(as defined in the ACGME Glossary of Terms) must be**
1503 **counted towards the 80-hour Maximum Weekly Hour Limit.**
1504 **(Core)**
1505
1506 **VI.G.3.** **Mandatory Time Free of Duty**
1507
1508 **Fellows must be scheduled for a minimum of one day free of duty**
1509 **every week (when averaged over four weeks). At-home call cannot**
1510 **be assigned on these free days.** **(Core)**
1511
1512 **VI.G.4.** **Maximum Duty Period Length**
1513
1514 **Duty periods of fellows may be scheduled to a maximum of 24 hours**
1515 **of continuous duty in the hospital.** **(Core)**
1516
1517 **VI.G.4.a)** **Programs must encourage fellows to use alertness**
1518 **management strategies in the context of patient care**
1519 **responsibilities. Strategic napping, especially after 16 hours**
1520 **of continuous duty and between the hours of 10:00 p.m. and**
1521 **8:00 a.m., is strongly suggested.** **(Detail)**
1522
1523 **VI.G.4.b)** **It is essential for patient safety and fellow education that**
1524 **effective transitions in care occur. Fellows may be allowed to**
1525 **remain on-site in order to accomplish these tasks; however,**
1526 **this period of time must be no longer than an additional four**
1527 **hours.** **(Core)**
1528
1529 **VI.G.4.c)** **Fellows must not be assigned additional clinical**
1530 **responsibilities after 24 hours of continuous in-house duty.**

1531 (Core)
1532
1533 **VI.G.4.d)** **In unusual circumstances, fellows, on their own initiative,**
1534 **may remain beyond their scheduled period of duty to**
1535 **continue to provide care to a single patient. Justifications for**
1536 **such extensions of duty are limited to reasons of required**
1537 **continuity for a severely ill or unstable patient, academic**
1538 **importance of the events transpiring, or humanistic attention**
1539 **to the needs of a patient or family.** (Detail)
1540
1541 **VI.G.4.d).(1)** **Under those circumstances, the fellow must:**
1542
1543 **VI.G.4.d).(1).(a)** **appropriately hand over the care of all other**
1544 **patients to the team responsible for their**
1545 **continuing care; and,** (Detail)
1546
1547 **VI.G.4.d).(1).(b)** **document the reasons for remaining to care for**
1548 **the patient in question and submit that**
1549 **documentation in every circumstance to the**
1550 **program director.** (Detail)
1551
1552 **VI.G.4.d).(2)** **The program director must review each submission of**
1553 **additional service, and track both individual fellow and**
1554 **program-wide episodes of additional duty.** (Detail)
1555
1556 **VI.G.5.** **Minimum Time Off between Scheduled Duty Periods**
1557
1558 **VI.G.5.a)** **Fellows must be prepared to enter the unsupervised practice**
1559 **of medicine and care for patients over irregular or extended**
1560 **periods.** (Outcome)
1561
1562 Anesthesiology subspecialty fellows are considered to be in the
1563 final year(s) of education.
1564
1565 **VI.G.5.a).(1)** **This preparation must occur within the context of the**
1566 **80-hour, maximum duty period length, and one-day-**
1567 **off-in-seven standards. While it is desirable that**
1568 **fellows have eight hours free of duty between**
1569 **scheduled duty periods, there may be circumstances**
1570 **when these fellows must stay on duty to care for their**
1571 **patients or return to the hospital with fewer than eight**
1572 **hours free of duty.** (Detail)
1573
1574 **VI.G.5.a).(1).(a)** **Circumstances of return-to-hospital activities**
1575 **with fewer than eight hours away from the**
1576 **hospital by fellows must be monitored by the**
1577 **program director.** (Detail)
1578
1579 VI.G.5.a).(1).(b) The Review Committee defines such
1580 circumstances as: required continuity of care for a
1581 severely ill or unstable patient, or a complex patient

with whom the fellow has been involved; events of exceptional educational value; or humanistic attention to the needs of a patient or family. (Detail)

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

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

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

Fellows must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period). (Core)

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by fellows on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. (Core)

VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow. (Core)

VI.G.8.b) Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period". (Detail)

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*__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 Principles Recognition
For programs seeking Osteopathic Principles Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable. (http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf)