Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
Int.A.	**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 diverse group of physicians brings to medical care, and the importance of inclusive 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.***	[None]	***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 diverse group of physicians brings to medical care, and the importance of inclusive 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.***
Int.A. - (Continued)	***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 achieved, fellows develop mentored relationships built on an infrastructure that promotes collaborative research.***	**[None] - (Continued)**	***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 achieved, fellows develop mentored relationships built on an infrastructure that promotes collaborative research.***
Int.B.	**Definition of Subspecialty** Obstetric anesthesiology is the subspecialty of anesthesiology devoted to the comprehensive anesthetic management of patients during pregnancy and the puerperium.	**[None]**	**Definition of Subspecialty** *Obstetric anesthesiology is the subspecialty of anesthesiology devoted to the comprehensive anesthetic management of patients during pregnancy and the puerperium.*

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Int.C.	**Length of Educational Program** The educational program in obstetric anesthesiology must be 12 months in length. (Core)*	**4.1.**	**Length of Program** The educational program in obstetric anesthesiology must be 12 months in length. (Core)
I.	**Oversight**	**Section 1**	**Section 1: Oversight**
I.A.	**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.***	**[None]**	***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.***
I.A.1.	**The program must be sponsored by one ACGME-accredited Sponsoring Institution.** (Core)	**1.1.**	**The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)**
I.B.	**Participating Sites** ***A participating site is an organization providing educational experiences or educational assignments/rotations for fellows.***	**[None]**	***Participating Sites*** ***A participating site is an organization providing educational experiences or educational assignments/rotations for fellows.***
I.B.1.	**The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)**	**1.2.**	**The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)**
I.B.1.a)	The Sponsoring Institution must also sponsor ACGME-accredited residency programs in anesthesiology and obstetrics and gynecology. (Core)	1.2.a.	The Sponsoring Institution must also sponsor ACGME-accredited residency programs in anesthesiology and obstetrics and gynecology. (Core)
I.B.1.b)	There must be interaction between the anesthesiology residency and the fellowship that results in coordination of educational, clinical, and investigative activities. (Detail)	1.2.b.	There must be interaction between the anesthesiology residency and the fellowship that results in coordination of educational, clinical, and investigative activities. (Detail)
I.B.1.c)	There must be an active maternal fetal medicine and neonatology service that is regularly involved in multidisciplinary care. (Core)	1.2.c.	There must be an active maternal fetal medicine and neonatology service that is regularly involved in multidisciplinary care. (Core)
I.B.2.	**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.**	**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)**
I.B.2.a)	**The PLA must:**	**[None]**	
I.B.2.a).(1)	**be renewed at least every 10 years; and, (Core)**	**1.3.a.**	**The PLA must be renewed at least every 10 years. (Core)**
I.B.2.a).(2)	**be approved by the designated institutional official (DIO). (Core)**	**1.3.b.**	**The PLA must be approved by the designated institutional official (DIO). (Core)**
I.B.3.	**The program must monitor the clinical learning and working environment at all participating sites. (Core)**	**1.4.**	**The program must monitor the clinical learning and working environment at all participating sites. (Core)**
I.B.3.a)	**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)**	**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)**

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I.B.4.	**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)**	**1.6.**	**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)**
I.C.	**Workforce Recruitment and Retention** **The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents (if present), fellows, faculty members, senior administrative GME staff members, and other relevant members of its academic community. (Core)**	**1.7.**	**Workforce Recruitment and Retention** **The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents (if present), fellows, faculty members, senior administrative GME staff members, and other relevant members of its academic community. (Core)**
I.D.	**Resources**	**1.8.**	**Resources** **The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for fellow education. (Core)**
I.D.1.	**The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for fellow education. (Core)**	**1.8.**	**Resources** **The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for fellow education. (Core)**
I.D.1.a)	Clinical facilities must include:	[None]	
I.D.1.a).(1)	a designated area for labor and delivery which includes labor rooms, and cesarean/operative delivery rooms; (Core)	1.8.a.	Clinical facilities must include a designated area for labor and delivery which includes labor rooms, and cesarean/operative delivery rooms. (Core)
I.D.1.a).(2)	maternal and fetal monitoring and advanced life-support equipment; (Core)	1.8.b.	Clinical facilities must include maternal and fetal monitoring and advanced life-support equipment. (Core)
I.D.1.a).(3)	a post-anesthesia care unit (PACU) or Labor-Delivery-Postpartum rooms designed and equipped for the collaborative management of post-operative obstetric patients by anesthesiologists and obstetrician-gynecologists; and, (Core)	1.8.c.	Clinical facilities must include a post-anesthesia care unit (PACU) or Labor-Delivery-Postpartum rooms designed and equipped for the collaborative management of post-operative obstetric patients by anesthesiologists and obstetrician-gynecologists. (Core)
I.D.1.a).(4)	a clinical laboratory that provides prompt and readily available diagnostic and laboratory measurements pertinent to the care of obstetric patients. (Core)	1.8.d.	Clinical facilities must include a clinical laboratory that provides prompt and readily available diagnostic and laboratory measurements pertinent to the care of obstetric patients. (Core)
I.D.1.b)	There must be access to an ultrasound machine housed in the labor and delivery unit for patient management using point-of-care ultrasound. (Core)	1.8.e.	There must be access to an ultrasound machine housed in the labor and delivery unit for patient management using point-of-care ultrasound. (Core)
I.D.1.c)	There must be facilities and space for the education of fellows, including meeting space, conference space, space for academic activities, and access to computers. (Core)	1.8.f.	There must be facilities and space for the education of fellows, including meeting space, conference space, space for academic activities, and access to computers. (Core)
I.D.1.d)	The institution must implement bundles of maternal and neonatal care designed to prevent severe maternal morbidity and mortality, including those available from state, national, or international organizations. (Core)	1.8.g.	The institution must implement bundles of maternal and neonatal care designed to prevent severe maternal morbidity and mortality, including those available from state, national, or international organizations. (Core)
I.D.1.e)	The patient population must include high-risk obstetric patients. (Core)	1.8.h.	The patient population must include high-risk obstetric patients. (Core)
I.D.2.	**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:**	**1.9.**	**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:**
I.D.2.a)	**access to food while on duty; (Core)**	**1.9.a.**	**access to food while on duty; (Core)**
I.D.2.b)	**safe, quiet, clean, and private sleep/rest facilities available and accessible for fellows with proximity appropriate for safe patient care; (Core)**	**1.9.b.**	**safe, quiet, clean, and private sleep/rest facilities available and accessible for fellows with proximity appropriate for safe patient care; (Core)**

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I.D.2.c)	clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)	1.9.c.	clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)
I.D.2.d)	security and safety measures appropriate to the participating site; and, (Core)	1.9.d.	security and safety measures appropriate to the participating site; and, (Core)
I.D.2.e)	accommodations for fellows with disabilities consistent with the Sponsoring Institution's policy. (Core)	1.9.e.	accommodations for fellows with disabilities consistent with the Sponsoring Institution's policy. (Core)
I.D.3.	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.	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)
I.E.	Other Learners and Health Care Personnel The presence of other learners and other 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)	1.11.	Other Learners and Health Care Personnel The presence of other learners and other 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)
II.	Personnel	Section 2	Section 2: Personnel
II.A.	Program Director	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)
II.A.1.	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)	2.1.	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)
II.A.1.a)	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)	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)
II.A.1.a).(1)	Final approval of the program director resides with the Review Committee. (Core)	2.2.a.	Final approval of the program director resides with the Review Committee. (Core)
II.A.2.	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.	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)

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II.A.2.a)	At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program. Additional support for program leadership must be provided as specified below. This additional support may be for the program director only or divided among the program director and one or more associate (or assistant) program directors. (Core) Number of Approved Fellow Positions: 1-3 | Minimum Support Required (FTE) for the Program Director: 0.1 | Minimum Additional Support Required (FTE) for Program Leadership in Aggregate: 0.025 | Total Minimum Program Leadership Support: 0.125 Number of Approved Fellow Positions: 4-6 | Minimum Support Required (FTE) for the Program Director: 0.15 | Minimum Additional Support Required (FTE) for Program Leadership in Aggregate: 0.05 | Total Minimum Program Leadership Support: 0.2 Number of Approved Fellow Positions: 7-9 | Minimum Support Required (FTE) for the Program Director: 0.2 | Minimum Additional Support Required (FTE) for Program Leadership in Aggregate: 0.1 | Total Minimum Program Leadership Support: 0.3 Number of Approved Fellow Positions: 10-14 | Minimum Support Required (FTE) for the Program Director: 0.2 | Minimum Additional Support Required (FTE) for Program Leadership in Aggregate: 0.15 | Total Minimum Program Leadership Support: 0.35 Number of Approved Fellow Positions: 15 and over | Minimum Support Required (FTE) for the Program Director: 0.2 | Minimum Additional Support Required (FTE) for Program Leadership in Aggregate: 0.2 | Total Minimum Program Leadership Support: 0.4	2.3.a.	At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program. Additional support for program leadership must be provided as specified below. This additional support may be for the program director only or divided among the program director and one or more associate (or assistant) program directors. (Core) Number of Approved Fellow Positions: 1-3 | Minimum Support Required (FTE) for the Program Director: 0.1 | Minimum Additional Support Required (FTE) for Program Leadership in Aggregate: 0.025 | Total Minimum Program Leadership Support: 0.125 Number of Approved Fellow Positions: 4-6 | Minimum Support Required (FTE) for the Program Director: 0.15 | Minimum Additional Support Required (FTE) for Program Leadership in Aggregate: 0.05 | Total Minimum Program Leadership Support: 0.2 Number of Approved Fellow Positions: 7-9 | Minimum Support Required (FTE) for the Program Director: 0.2 | Minimum Additional Support Required (FTE) for Program Leadership in Aggregate: 0.1 | Total Minimum Program Leadership Support: 0.3 Number of Approved Fellow Positions: 10-14 | Minimum Support Required (FTE) for the Program Director: 0.2 | Minimum Additional Support Required (FTE) for Program Leadership in Aggregate: 0.15 | Total Minimum Program Leadership Support: 0.35 Number of Approved Fellow Positions: 15 and over | Minimum Support Required (FTE) for the Program Director: 0.2 | Minimum Additional Support Required (FTE) for Program Leadership in Aggregate: 0.2 | Total Minimum Program Leadership Support: 0.4
II.A.3.	**Qualifications of the program director:**	**2.4.**	**Qualifications of the Program Director** **The program director must possess subspecialty expertise and qualifications acceptable to the Review Committee. (Core)**
II.A.3.a)	**must include subspecialty expertise and qualifications acceptable to the Review Committee; and, (Core)**	**2.4.**	**Qualifications of the Program Director** **The program director must possess subspecialty expertise and qualifications acceptable to the Review Committee. (Core)**
II.A.3.b)	**must include current certification in the specialty for which they are the program director by the American Board of** Anesthesiology **or by the American Osteopathic Board of** Anesthesiology, **or subspecialty qualifications that are acceptable to the Review Committee. (Core)** [Note that while the Common Program Requirements deem certification by a member board of the American Board of Medical Specialties (ABMS) or a certifying board of the American Osteopathic Association (AOA) acceptable, there is no ABMS or AOA board that offers certification in this subspecialty]	**2.4.a.**	**The program director must possess current certification in the specialty for which they are the program director by the American Board of** Anesthesiology **or by the American Osteopathic Board of** Anesthesiology, **or subspecialty qualifications that are acceptable to the Review Committee. (Core)** [Note that while the Common Program Requirements deem certification by a member board of the American Board of Medical Specialties (ABMS) or a certifying board of the American Osteopathic Association (AOA) acceptable, there is no ABMS or AOA board that offers certification in this subspecialty]

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II.A.3.c)	must include completion of an ACGME-accredited obstetric anesthesiology fellowship, or at least three years' participation in a clinical obstetric anesthesiology fellowship as a faculty member; (Core)	2.4.b.	The program director must demonstrate completion of an ACGME-accredited obstetric anesthesiology fellowship, or at least three years' participation in a clinical obstetric anesthesiology fellowship as a faculty member. (Core)
II.A.3.d)	must include at least three years of post-fellowship experience in clinical obstetric anesthesiology; (Detail)	2.4.c.	The program director must have at least three years of post-fellowship experience in clinical obstetric anesthesiology. (Detail)
II.A.3.e)	must include current appointment as a member of the anesthesiology faculty at the primary clinical site; (Core)	2.4.d.	The program director must have current appointment as a member of the anesthesiology faculty at the primary clinical site. (Core)
II.A.3.f)	must include devotion of at least 50 percent of the program director's clinical, educational, and academic time to the anesthetic care of pregnant patients; and, (Core)	2.4.e.	The program director must devote at least 50 percent of the program director's clinical, educational, and academic time to the anesthetic care of pregnant patients. (Core)
II.A.3.g)	must include demonstration of ongoing academic achievements appropriate to the subspecialty, including publications, the development of educational programs, or the conduct of research. (Core)	2.4.f.	The program director must demonstrate ongoing academic achievements appropriate to the subspecialty, including publications, the development of educational programs, or the conduct of research. (Core)
II.A.4.	**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.**	**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)**
II.A.4.a)	**The program director must:**	**[None]**	
II.A.4.a).(1)	**be a role model of professionalism; (Core)**	**2.5.a.**	**The program director must be a role model of professionalism. (Core)**
II.A.4.a).(2)	**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)**	**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)**
II.A.4.a).(3)	**administer and maintain a learning environment conducive to educating the fellows in each of the ACGME Competency domains; (Core)**	**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)**
II.A.4.a).(4)	**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)**	**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)**
II.A.4.a).(5)	**have the authority to remove fellows from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)**	**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)**
II.A.4.a).(6)	**submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)**	**2.5.f.**	**The program director must submit accurate and complete information required and requested by the DIO, GMEC, and ACGME. (Core)**
II.A.4.a).(7)	**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.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)**
II.A.4.a).(8)	**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)**	**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)**

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II.A.4.a).(9)	ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)	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)
II.A.4.a).(9).(a)	Fellows must not be required to sign a non-competition guarantee or restrictive covenant. (Core)	3.1.	Fellows must not be required to sign a non-competition guarantee or restrictive covenant. (Core)
II.A.4.a).(10)	document verification of education for all fellows within 30 days of completion of or departure from the program; (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)
II.A.4.a).(11)	provide verification of an individual fellow's education upon the fellow's request, within 30 days; and, (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)
II.B.	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.*	[None]	*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.*
II.B.1.	There must be a sufficient number of faculty members with competence to instruct and supervise all fellows. (Core)	2.6.	There must be a sufficient number of faculty members with competence to instruct and supervise all fellows. (Core)
II.B.2	Faculty members must:	[None]	
II.B.2.a)	be role models of professionalism; (Core)	2.7.	Faculty Responsibilities Faculty members must be role models of professionalism. (Core)
II.B.2.b)	demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care; (Core)	2.7.a.	Faculty members must demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care. (Core)
II.B.2.c)	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.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)
II.B.2.d)	administer and maintain an educational environment conducive to educating fellows; (Core)	2.7.c.	Faculty members must administer and maintain an educational environment conducive to educating fellows. (Core)

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II.B.2.e)	**regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)**	**2.7.d.**	**Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Core)**
II.B.2.f)	**pursue faculty development designed to enhance their skills at least annually. (Core)**	**2.7.e.**	**Faculty members must pursue faculty development designed to enhance their skills at least annually. (Core)**
II.B.2.g)	include physicians certified through a member board of the ABMS or certifying board of the AOA in obstetrics and gynecology, maternal-fetal medicine, and neonatology, must be available for consultations and the collaborative management of peripartum patients, as well as instruction and supervision of fellows; and, (Core)	2.7.f.	The faculty must include physicians certified through a member board of the ABMS or certifying board of the AOA in obstetrics and gynecology, maternal-fetal medicine, and neonatology, must be available for consultations and the collaborative management of peripartum patients, as well as instruction and supervision of fellows. (Core)
II.B.2.h)	include at least one individual who is certified in critical care medicine by a member board of the ABMS or AOA and who practices in an ICU that cares for obstetric patients. (Core)	2.7.g.	The faculty must include at least one individual who is certified in critical care medicine by a member board of the ABMS or AOA and who practices in an ICU that cares for obstetric patients. (Core)
II.B.3.	**Faculty Qualifications**	**2.8.**	**Faculty Qualifications** **Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)**
II.B.3.a)	**Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)**	**2.8.**	**Faculty Qualifications** **Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)**
II.B.3.b)	**Subspecialty physician faculty members must:**	**[None]**	
II.B.3.b).(1)	**have current certification in the specialty by the American Board of** Anesthesiology **or the American Osteopathic Board of** Anesthesiology**, or possess qualifications judged acceptable to the Review Committee. (Core)** [Note that while the Common Program Requirements deem certification by a member board of the American Board of Medical Specialties (ABMS) or a certifying board of the American Osteopathic Association (AOA) acceptable, there is no ABMS or AOA board that offers certification in this subspecialty]	**2.9.**	**Subspecialty Physician Faculty Members** **Subspecialty physician faculty members must have current certification in the specialty by the American Board of** Anesthesiology **or the American Osteopathic Board of** Anesthesiology**, or possess qualifications judged acceptable to the Review Committee. (Core)** [Note that while the Common Program Requirements deem certification by a member board of the American Board of Medical Specialties (ABMS) or a certifying board of the American Osteopathic Association (AOA) acceptable, there is no ABMS or AOA board that offers certification in this subspecialty]
II.B.3.b).(2)	have fellowship education or post-residency experience in clinical obstetric anesthesiology that meets or exceeds completion of a one-year obstetric anesthesiology program. (Core)	2.9.b.	Subspecialty physician faculty members must have fellowship education or post-residency experience in clinical obstetric anesthesiology that meets or exceeds completion of a one-year obstetric anesthesiology program. (Core)
II.B.3.c)	**Any other specialty 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.a.**	**Any other specialty 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)**
II.B.4.	**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)**	**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)**

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II.B.4.a)	**Faculty members must complete the annual ACGME Faculty Survey. (Core)**	**2.10.a.**	**Faculty members must complete the annual ACGME Faculty Survey. (Core)**
II.B.4.b)	There must be at least three core program faculty members, including the program director. (Core)	2.10.b.	There must be at least three core program faculty members, including the program director. (Core)
II.B.4.c)	For programs with four or more fellows, a ratio of at least one faculty member to one fellow must be maintained. (Core)	2.10.c.	For programs with four or more fellows, a ratio of at least one faculty member to one fellow must be maintained. (Core)
II.C.	**Program Coordinator**	**2.11.**	**Program Coordinator** **There must be a program coordinator. (Core)**
II.C.1.	**There must be a program coordinator. (Core)**	**2.11.**	**Program Coordinator** **There must be a program coordinator. (Core)**
II.C.2.	**The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)**	**2.11.a.**	**The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)**
II.C.2.a)	The program coordinator(s) must be provided with support equal to a dedicated minimum of 20 percent FTE for administration of the program. Additional administrative support must be provided based on the program size as follows: (Core) Number of Approved Fellow Positions: 2 | Minimum FTE Coordinator(s) Required : 0.22 Number of Approved Fellow Positions: 3 | Minimum FTE Coordinator(s) Required : 0.24 Number of Approved Fellow Positions: 4 | Minimum FTE Coordinator(s) Required : 0.26 Number of Approved Fellow Positions: >4 | Minimum FTE Coordinator(s) Required : Additional 0.02 FTE per fellow	2.11.b.	The program coordinator(s) must be provided with support equal to a dedicated minimum of 20 percent FTE for administration of the program. Additional administrative support must be provided based on the program size as follows: (Core) Number of Approved Fellow Positions: 2 | Minimum FTE Coordinator(s) Required : 0.22 Number of Approved Fellow Positions: 3 | Minimum FTE Coordinator(s) Required : 0.24 Number of Approved Fellow Positions: 4 | Minimum FTE Coordinator(s) Required : 0.26 Number of Approved Fellow Positions: >4 | Minimum FTE Coordinator(s) Required : Additional 0.02 FTE per fellow
II.D.	**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)**	**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)**
II.D.1.	There must be specialized nursing staff for the care of the critically ill newborn. (Core)	2.12.a.	There must be specialized nursing staff for the care of the critically ill newborn. (Core)
II.D.2.	There must be allied health staff and other support personnel necessary for the comprehensive care of patients during pregnancy. (Detail)	2.12.b.	There must be allied health staff and other support personnel necessary for the comprehensive care of patients during pregnancy. (Detail)
III.	**Fellow Appointments**	**Section 3**	**Section 3: Fellow Appointments**
III.A.	**Eligibility Criteria**	**[None]**	
III.A.1.	**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)**	**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)**

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III.A.1.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)**	**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)**
III.A.1.b)	Prior to appointment in the program, fellows must have successfully completed a program in anesthesiology that satisfies the requirements in III.A.1. (Core)	3.2.a.1.	Prior to appointment in the program, fellows must have successfully completed a program in anesthesiology that satisfies the requirements in 3.2. (Core)
III.A.1.c)	**Fellow Eligibility Exception** **The Review Committee for** Anesthesiology **will allow the following exception to the fellowship eligibility requirements:**	**3.2.b.**	**Fellow Eligibility Exception** **The Review Committee for** Anesthesiology **will allow the following exception to the fellowship eligibility requirements:**
III.A.1.c).(1)	**An ACGME-accredited fellowship program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1., but who does meet all of the following additional qualifications and conditions: (Core)**	**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)**
III.A.1.c).(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.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)**
III.A.1.c).(1).(b)	**review and approval of the applicant's exceptional qualifications by the GMEC; and, (Core)**	**3.2.b.1.b.**	**review and approval of the applicant's exceptional qualifications by the GMEC; and, (Core)**
III.A.1.c).(1).(c)	**verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification. (Core)**	**3.2.b.1.c.**	**verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification. (Core)**
III.A.1.c).(2)	**Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. (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)**
III.B.	**Fellow Complement** **The program director must not appoint more fellows than approved by the Review Committee. (Core)**	**3.3.**	**Fellow Complement** **The program director must not appoint more fellows than approved by the Review Committee. (Core)**
III.C.	**Fellow Transfers** **The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring fellow, and Milestones evaluations upon matriculation. (Core)**	**3.4.**	**Fellow Transfers** **The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring fellow, and Milestones evaluations upon matriculation. (Core)**

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IV.	**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.**	Section 4	**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.***
IV.A.	**Educational Components** **The curriculum must contain the following educational components:**	4.2.	**Educational Components** **The curriculum must contain the following educational components:**
IV.A.1.	**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)**	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)**
IV.A.2.	**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.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)**
IV.A.3.	**delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and graded supervision in their subspecialty; (Core)**	4.2.c.	**delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and graded supervision in their subspecialty; (Core)**
IV.A.4.	**structured educational activities beyond direct patient care; and, (Core)**	4.2.d.	**structured educational activities beyond direct patient care; and, (Core)**
IV.A.4.a)	**Fellows must be provided with protected time to participate in core didactic activities. (Core)**	4.11.	**Didactic and Clinical Experiences** **Fellows must be provided with protected time to participate in core didactic activities. (Core)**
IV.A.5.	**formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)**	4.2.e.	**formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)**
IV.B.	**ACGME Competencies**	[None]	**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.***

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IV.B.1.	**The program must integrate the following ACGME Competencies into the curriculum:**	**[None]**	**The program must integrate all ACGME Competencies into the curriculum.**
IV.B.1.a)	**Professionalism** **Fellows must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)**	**4.3.**	**ACGME Competencies – Professionalism** **Fellows must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)**
IV.B.1.b)	**Patient Care and Procedural Skills**	**[None]**	
IV.B.1.b).(1)	**Fellows must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (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, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)**
IV.B.1.b).(1).(a)	Fellows must demonstrate competence in the comprehensive analgesic/anesthetic management of deliveries, including: (Core)	4.4.a.	Fellows must demonstrate competence in the comprehensive analgesic/anesthetic management of deliveries, including: (Core)
IV.B.1.b).(1).(a).(i)	planned vaginal deliveries with a high-risk maternal co-morbidity, to include obtaining the appropriate diagnostic testing and consultation and communication with the multidisciplinary team; (Core)	4.4.a.1.	planned vaginal deliveries with a high-risk maternal co-morbidity, to include obtaining the appropriate diagnostic testing and consultation and communication with the multidisciplinary team; (Core)
IV.B.1.b).(1).(a).(ii)	planned vaginal deliveries with high-risk fetal conditions, to include appropriate interpretation of fetal surveillance and consultation with maternal-fetal medicine specialists and neonatologists as to the appropriate obstetric interventions and their timing; (Core)	4.4.a.2.	planned vaginal deliveries with high-risk fetal conditions, to include appropriate interpretation of fetal surveillance and consultation with maternal-fetal medicine specialists and neonatologists as to the appropriate obstetric interventions and their timing; (Core)
IV.B.1.b).(1).(a).(iii)	Cesarean deliveries with a high-risk maternal co-morbidity, to include application of broad anesthetic principles and techniques in creating a comprehensive anesthetic care plan and collaborative management between anesthesiologists and obstetricians of patients with abnormal placentation; and, (Core)	4.4.a.3.	Cesarean deliveries with a high-risk maternal co-morbidity, to include application of broad anesthetic principles and techniques in creating a comprehensive anesthetic care plan and collaborative management between anesthesiologists and obstetricians of patients with abnormal placentation; and, (Core)
IV.B.1.b).(1).(a).(iv)	Cesarean deliveries with a high-risk fetal condition, to include interpretation of fetal surveillance and consultation with maternal-fetal medicine specialists and neonatologists as to the appropriate obstetric interventions and their timing. (Core)	4.4.a.4.	Cesarean deliveries with a high-risk fetal condition, to include interpretation of fetal surveillance and consultation with maternal-fetal medicine specialists and neonatologists as to the appropriate obstetric interventions and their timing. (Core)
IV.B.1.b).(1).(b)	Fellows must demonstrate competence to manage anesthetics during the first, second, or third trimesters, other than for Cesarean delivery, including antepartum procedures involving prenatal diagnosis and fetal treatment, maternal cardioversion, or electroconvulsive therapy. (Core)	4.4.b.	Fellows must demonstrate competence to manage anesthetics during the first, second, or third trimesters, other than for Cesarean delivery, including antepartum procedures involving prenatal diagnosis and fetal treatment, maternal cardioversion, or electroconvulsive therapy. (Core)
IV.B.1.b).(1).(c)	Fellows must demonstrate competence to manage general anesthetics for Cesarean or vaginal delivery. (Core)	4.4.c.	Fellows must demonstrate competence to manage general anesthetics for Cesarean or vaginal delivery. (Core)
IV.B.1.b).(1).(d)	Fellows must demonstrate proficiency and skill preparing for and providing care, including developing a care plan, which acknowledges the patient's birth plan goals. (Core)	4.4.d.	Fellows must demonstrate proficiency and skill preparing for and providing care, including developing a care plan, which acknowledges the patient's birth plan goals. (Core)
IV.B.1.b).(1).(e)	Fellows must demonstrate competence in the anesthesia critical care of patients during the puerperium. (Core)	4.4.e.	Fellows must demonstrate competence in the anesthesia critical care of patients during the puerperium. (Core)
IV.B.1.b).(2)	**Fellows must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)**	**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)**
IV.B.1.b).(2).(a)	Fellows must demonstrate competence in management of high-risk maternal co-morbidity and high-risk vaginal and Cesarean deliveries, as well as antenatal procedures. (Core)	4.5.a.	Fellows must demonstrate competence in management of high-risk maternal co-morbidity and high-risk vaginal and Cesarean deliveries, as well as antenatal procedures. (Core)

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IV.B.1.c)	**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.**	**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)**
IV.B.1.c).(1)	Fellows must demonstrate knowledge of the anesthetic implications of the altered maternal physiologic state, the impact of interventions on the mother and fetus/neonate, and the care of the high-risk pregnant patient, of the following areas: (Core)	4.6.a.	Fellows must demonstrate knowledge of the anesthetic implications of the altered maternal physiologic state, the impact of interventions on the mother and fetus/neonate, and the care of the high-risk pregnant patient, of the following areas: (Core)
IV.B.1.c).(1).(a)	physiologic changes associated with pregnancy; (Core)	4.6.a.1.	physiologic changes associated with pregnancy; (Core)
IV.B.1.c).(1).(b)	normal and abnormal fetal development and the potential teratogenicity of exposures (e.g., medications, radiation) during pregnancy; (Core)	4.6.a.2.	normal and abnormal fetal development and the potential teratogenicity of exposures (e.g., medications, radiation) during pregnancy; (Core)
IV.B.1.c).(1).(c)	fetal and placental physiology and pathophysiology, models of uteroplacental perfusion, and pharmacokinetics of placental transfer; (Core)	4.6.a.3.	fetal and placental physiology and pathophysiology, models of uteroplacental perfusion, and pharmacokinetics of placental transfer; (Core)
IV.B.1.c).(1).(d)	neonatal physiology and advanced neonatal resuscitation; (Core)	4.6.a.4.	neonatal physiology and advanced neonatal resuscitation; (Core)
IV.B.1.c).(1).(e)	medical disease and pregnancy, including hypertensive disorders, obesity, respiratory disorders, cardiac disorders (congenital and acquired), dysrhythmias, gastrointestinal diseases, endocrine disorders, autoimmune disorders, hematologic and coagulation disorders, oncologic disorders, musculoskeletal and connective tissue disorders (congenital and acquired), substance use disorders (SUDs), opioid dependence, infectious diseases (e.g., HIV/AIDS, influenza, Zika, COVID-19), and psychiatric diseases; (Core)	4.6.a.5.	medical disease and pregnancy, including hypertensive disorders, obesity, respiratory disorders, cardiac disorders (congenital and acquired), dysrhythmias, gastrointestinal diseases, endocrine disorders, autoimmune disorders, hematologic and coagulation disorders, oncologic disorders, musculoskeletal and connective tissue disorders (congenital and acquired), substance use disorders (SUDs), opioid dependence, infectious diseases (e.g., HIV/AIDS, influenza, Zika, COVID-19), and psychiatric diseases; (Core)
IV.B.1.c).(1).(f)	obstetric management of normal and abnormal labor, induction of labor, trial of labor after Cesarean delivery, management of routine, urgent, and emergent delivery, and management of instrumented vaginal delivery; (Core)	4.6.a.6.	obstetric management of normal and abnormal labor, induction of labor, trial of labor after Cesarean delivery, management of routine, urgent, and emergent delivery, and management of instrumented vaginal delivery; (Core)
IV.B.1.c).(1).(g)	medications affecting the uterus, tocolytic therapy, methods of tocolysis, uterotonic medications, and effects on anesthetic management; (Core)	4.6.a.7.	medications affecting the uterus, tocolytic therapy, methods of tocolysis, uterotonic medications, and effects on anesthetic management; (Core)
IV.B.1.c).(1).(h)	labor pain, including pain pathways, experimental models for studying pain of labor, biochemical mechanisms of labor pain, and modalities for treating labor pain; (Core)	4.6.a.8.	labor pain, including pain pathways, experimental models for studying pain of labor, biochemical mechanisms of labor pain, and modalities for treating labor pain; (Core)
IV.B.1.c).(1).(i)	local anesthetic use in obstetrics, including pregnancy-related effects on pharmacodynamics and pharmacokinetics; recognition and treatment of complications; lipid rescue of local anesthetic cardiotoxicity; effects on the fetus in different settings, including prematurity, asphyxia, fetal cardiovascular and neurological effects; and fetal drug disposition; (Core)	4.6.a.9.	local anesthetic use in obstetrics, including pregnancy-related effects on pharmacodynamics and pharmacokinetics; recognition and treatment of complications; lipid rescue of local anesthetic cardiotoxicity; effects on the fetus in different settings, including prematurity, asphyxia, fetal cardiovascular and neurological effects; and fetal drug disposition; (Core)
IV.B.1.c).(1).(j)	neuraxial opioid use in obstetrics, including prevention, recognition, and treatment of complications and post-operative monitoring; effects on the fetus; and fetal/neonatal drug disposition; (Core)	4.6.a.10.	neuraxial opioid use in obstetrics, including prevention, recognition, and treatment of complications and post-operative monitoring; effects on the fetus; and fetal/neonatal drug disposition; (Core)
IV.B.1.c).(1).(k)	regional anesthetic techniques; (Core)	4.6.a.11.	regional anesthetic techniques; (Core)
IV.B.1.c).(1).(l)	vasoactive medication; (Core)	4.6.a.12.	vasoactive medication; (Core)
IV.B.1.c).(1).(m)	use of circulatory support devices, such as extracorporeal membrane oxygenation (ECMO) for complex parturient management; (Core)	4.6.a.13.	use of circulatory support devices, such as extracorporeal membrane oxygenation (ECMO) for complex parturient management; (Core)

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IV.B.1.c).(1).(n)	general anesthesia use in obstetrics, including recognition and treatment of complications, alternatives for securing the airway in pregnant patients (anticipated/unanticipated difficult airway), consequences on utero-placental perfusion, and opposing maternal-fetal considerations regarding the use of general anesthesia; (Core)	4.6.a.14.	general anesthesia use in obstetrics, including recognition and treatment of complications, alternatives for securing the airway in pregnant patients (anticipated/unanticipated difficult airway), consequences on utero-placental perfusion, and opposing maternal-fetal considerations regarding the use of general anesthesia; (Core)
IV.B.1.c).(1).(o)	anesthetic and obstetric management of obstetric complications and emergencies, including intrauterine fetal demise, placental abruption, placenta previa, morbidly adherent placenta, vasa previa, umbilical cord prolapse, uterine rupture, uterine atony, uterine inversion, amniotic fluid embolism, and postpartum hemorrhage; (Core)	4.6.a.15.	anesthetic and obstetric management of obstetric complications and emergencies, including intrauterine fetal demise, placental abruption, placenta previa, morbidly adherent placenta, vasa previa, umbilical cord prolapse, uterine rupture, uterine atony, uterine inversion, amniotic fluid embolism, and postpartum hemorrhage; (Core)
IV.B.1.c).(1).(p)	anesthetic and obstetric management of hypertensive disorders of pregnancy, including study of preeclampsia; etiology and epidemiology; pathophysiology; biomolecular and genetic changes; peripartum care; and maternal morbidity and mortality from hypertensive disorders of pregnancy; (Core)	4.6.a.16.	anesthetic and obstetric management of hypertensive disorders of pregnancy, including study of preeclampsia; etiology and epidemiology; pathophysiology; biomolecular and genetic changes; peripartum care; and maternal morbidity and mortality from hypertensive disorders of pregnancy; (Core)
IV.B.1.c).(1).(q)	recognition and prevention of impending maternal morbidity or mortality, including critical events and recognition of clinical warning signs (e.g., maternal early warning systems); (Core)	4.6.a.17.	recognition and prevention of impending maternal morbidity or mortality, including critical events and recognition of clinical warning signs (e.g., maternal early warning systems); (Core)
IV.B.1.c).(1).(r)	bundles of maternal and neonatal care designed to prevent severe maternal morbidity and mortality, including those available from state, national, or international organizations; (Core)	4.6.a.18.	bundles of maternal and neonatal care designed to prevent severe maternal morbidity and mortality, including those available from state, national, or international organizations; (Core)
IV.B.1.c).(1).(s)	cardiac arrest in pregnancy; cardiopulmonary resuscitation (CPR), peri-mortem Cesarean delivery, and advanced cardiac life support in pregnancy; ECMO in pregnancy; and implementation of cognitive aids and/or checklists and unit preparation for maternal cardiac arrest, including team training, crisis communication, and simulation; (Core)	4.6.a.19.	cardiac arrest in pregnancy; cardiopulmonary resuscitation (CPR), peri-mortem Cesarean delivery, and advanced cardiac life support in pregnancy; ECMO in pregnancy; and implementation of cognitive aids and/or checklists and unit preparation for maternal cardiac arrest, including team training, crisis communication, and simulation; (Core)
IV.B.1.c).(1).(t)	postpartum tubal ligation and timing, including policies to ensure availability, regulatory and consent issues, ethics, obstetric considerations, counseling, the epidemiologic effects of delaying requested postpartum ligation procedures, and reliable contraceptive alternatives; (Core)	4.6.a.20.	postpartum tubal ligation and timing, including policies to ensure availability, regulatory and consent issues, ethics, obstetric considerations, counseling, the epidemiologic effects of delaying requested postpartum ligation procedures, and reliable contraceptive alternatives; (Core)
IV.B.1.c).(1).(u)	optimizing post-Cesarean recovery; (Core)	4.6.a.21.	optimizing post-Cesarean recovery; (Core)
IV.B.1.c).(1).(v)	anesthetic management of non-delivery obstetric procedures (e.g., dilation and curettage, dilation and evacuation, cerclage placement, and external cephalic version); (Core)	4.6.a.22.	anesthetic management of non-delivery obstetric procedures (e.g., dilation and curettage, dilation and evacuation, cerclage placement, and external cephalic version); (Core)
IV.B.1.c).(1).(w)	non-obstetric surgery during pregnancy, including timing, laparoscopy, and cardiorespiratory effects on the mother and fetus, fetal monitoring considerations, post-operative analgesia, and, in the postpartum patient, breastfeeding after surgery; (Core)	4.6.a.23.	non-obstetric surgery during pregnancy, including timing, laparoscopy, and cardiorespiratory effects on the mother and fetus, fetal monitoring considerations, post-operative analgesia, and, in the postpartum patient, breastfeeding after surgery; (Core)
IV.B.1.c).(1).(x)	effects of maternal medications and anesthetic technique on breastfeeding, including effects of surgical anesthesia, labor analgesia, and postpartum analgesia; (Core)	4.6.a.24.	effects of maternal medications and anesthetic technique on breastfeeding, including effects of surgical anesthesia, labor analgesia, and postpartum analgesia; (Core)
IV.B.1.c).(1).(y)	antepartum and intrapartum fetal monitoring, including the application of ultrasonography, biophysical profile, electronic fetal heart monitoring, assessment of uterine contraction pattern and labor, and acid-base status of the fetus; (Core)	4.6.a.25.	antepartum and intrapartum fetal monitoring, including the application of ultrasonography, biophysical profile, electronic fetal heart monitoring, assessment of uterine contraction pattern and labor, and acid-base status of the fetus; (Core)
IV.B.1.c).(1).(z)	effects of general anesthesia on the mother and fetus, and the effects of fetal circulation and placental transfer on newborn adaptation; (Core)	4.6.a.26.	effects of general anesthesia on the mother and fetus, and the effects of fetal circulation and placental transfer on newborn adaptation; (Core)

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IV.B.1.c).(1).(aa)	multidisciplinary care involving obstetrics, maternal-fetal medicine, cardiology, transfusion medicine, critical care, and neonatology; (Core)	4.6.a.27.	multidisciplinary care involving obstetrics, maternal-fetal medicine, cardiology, transfusion medicine, critical care, and neonatology; (Core)
IV.B.1.c).(1).(bb)	fundamentals of point-of-care ultrasound, image acquisition, and interpretation, including lung, gastric, cardiac, vascular, and neuraxial; (Core)	4.6.a.28.	fundamentals of point-of-care ultrasound, image acquisition, and interpretation, including lung, gastric, cardiac, vascular, and neuraxial; (Core)
IV.B.1.c).(1).(cc)	fetal treatment procedures, including indications, peri-operative considerations, and anesthetic management of mother and fetus for open, minimally invasive, and ex-utero intrapartum treatment (EXIT) procedures; (Core)	4.6.a.29.	fetal treatment procedures, including indications, peri-operative considerations, and anesthetic management of mother and fetus for open, minimally invasive, and ex-utero intrapartum treatment (EXIT) procedures; (Core)
IV.B.1.c).(1).(dd)	recognition of critically-ill pregnant patients; escalation of care, including regionalization of maternal care and Maternal Levels of Care; and transport and monitoring of critically ill pregnant patients within one hospital and between hospitals; (Core)	4.6.a.30.	recognition of critically-ill pregnant patients; escalation of care, including regionalization of maternal care and Maternal Levels of Care; and transport and monitoring of critically ill pregnant patients within one hospital and between hospitals; (Core)
IV.B.1.c).(1).(ee)	organization and management of an obstetric anesthesia service, health care delivery models, reimbursement, building a service, regulatory agencies with jurisdiction, contract negotiation, economics, billing, government regulations, financial and budgeting considerations, and medical liability specific to labor and delivery; (Core)	4.6.a.31.	organization and management of an obstetric anesthesia service, health care delivery models, reimbursement, building a service, regulatory agencies with jurisdiction, contract negotiation, economics, billing, government regulations, financial and budgeting considerations, and medical liability specific to labor and delivery; (Core)
IV.B.1.c).(1).(ff)	legal and ethical issues during pregnancy, including consent issues related to blood refusal, pregnant minors, competency, and maternal autonomy; (Core)	4.6.a.32.	legal and ethical issues during pregnancy, including consent issues related to blood refusal, pregnant minors, competency, and maternal autonomy; (Core)
IV.B.1.c).(1).(gg)	psychosocial and social issues; (Core)	4.6.a.33.	psychosocial and social issues; (Core)
IV.B.1.c).(1).(hh)	medical economics and public health issues of patients during reproductive years as it applies to obstetric anesthesiology, including availability of obstetric analgesia, trial of labor after Cesarean (TOLAC), postpartum tubal ligation, and Cesarean delivery rates; (Core)	4.6.a.34.	medical economics and public health issues of patients during reproductive years as it applies to obstetric anesthesiology, including availability of obstetric analgesia, trial of labor after Cesarean (TOLAC), postpartum tubal ligation, and Cesarean delivery rates; (Core)
IV.B.1.c).(1).(ii)	maternal morbidity and mortality, including international, national, state, and local racial and economic determinants; and knowledge of maternal morbidity and mortality review boards; (Core)	4.6.a.35.	maternal morbidity and mortality, including international, national, state, and local racial and economic determinants; and knowledge of maternal morbidity and mortality review boards; (Core)
IV.B.1.c).(1).(jj)	regulatory policies and procedures governing the labor and delivery unit, obstetric operating rooms, and the obstetric PACU; and potential effects of societal, institutional, and governmental factors; (Core)	4.6.a.36.	regulatory policies and procedures governing the labor and delivery unit, obstetric operating rooms, and the obstetric PACU; and potential effects of societal, institutional, and governmental factors; (Core)
IV.B.1.c).(1).(kk)	principles and ethics of research in pregnant patients, their fetuses, and neonates; (Core)	4.6.a.37.	principles and ethics of research in pregnant patients, their fetuses, and neonates; (Core)
IV.B.1.c).(1).(ll)	processes involved in design, approval, and implementation of research and clinical trials; and, (Core)	4.6.a.38.	processes involved in design, approval, and implementation of research and clinical trials; and, (Core)
IV.B.1.c).(1).(mm)	research funding, including: (Core)	4.6.a.39.	research funding, including: (Core)
IV.B.1.c).(1).(mm).(i)	components of a research budget, to include direct and indirect costs; (Core)	4.6.a.39.a.	components of a research budget, to include direct and indirect costs; (Core)
IV.B.1.c).(1).(mm).(ii)	funding procurement mechanisms; and, (Core)	4.6.a.39.b.	funding procurement mechanisms; and, (Core)
IV.B.1.c).(1).(mm).(iii)	proficiency in acquisition and interpretation of cardiac and neuraxial ultrasound images. (Core)	4.6.a.39.c.	proficiency in acquisition and interpretation of cardiac and neuraxial ultrasound images. (Core)
IV.B.1.c).(2)	Fellows must have completed a course in neonatal resuscitation and received a course completion certificate prior to completion of the fellowship. (Core)	4.6.b.	Fellows must have completed a course in neonatal resuscitation and received a course completion certificate prior to completion of the fellowship. (Core)
IV.B.1.c).(3)	Fellows must maintain current certification in advanced cardiac life support skills. (Core)	4.6.c.	Fellows must maintain current certification in advanced cardiac life support skills. (Core)

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IV.B.1.d)	**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)**	4.7.	**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)**
IV.B.1.e)	**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)**	4.8.	**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)**
IV.B.1.f)	**Systems-based Practice** **Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (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 structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)**
IV.C.	**Curriculum Organization and Fellow Experiences**	4.10. - 4.12.	**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)** **4.11. Didactic and Clinical Experiences** **Fellows must be provided with protected time to participate in core didactic activities. (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)**
IV.C.1.	**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.	**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)**

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IV.C.1.a)	Clinical experiences should be structured to facilitate learning in a manner that allows 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.a.	Clinical experiences should be structured to facilitate learning in a manner that allows fellows to function as part of an effective interprofessional team that works together longitudinally with shared goals of patient safety and quality improvement. (Core)
IV.C.2.	**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)**	**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)**
IV.C.3.	The curriculum must be structured to include:	[None]	
IV.C.3.a)	interpretation of and demonstrated competence in fetal heart rate monitoring in the first three months of the program; (Core)	4.11.a.	The curriculum must be structured to include interpretation of and to demonstrate competence in fetal heart rate monitoring in the first three months of the program. (Core)
IV.C.3.b)	a minimum of seven months of operating room and labor and delivery clinical activity; (Detail)	4.11.b.	The curriculum must be structured to include a minimum of seven months of operating room and labor and delivery clinical activity. (Detail)
IV.C.3.c)	at least one contiguous two-week rotation in maternal-fetal medicine that includes experience in antepartum fetal testing and high-risk antepartum care; (Core)	4.11.c.	The curriculum must be structured to include at least one contiguous two-week rotation in maternal-fetal medicine that includes experience in antepartum fetal testing and high-risk antepartum care. (Core)
IV.C.3.d)	at least one contiguous two-week rotation in neonatology during which fellows provide routine neonatal evaluation and care; and, (Core)	4.11.d.	The curriculum must be structured to include at least one contiguous two-week rotation in neonatology during which fellows provide routine neonatal evaluation and care. (Core)
IV.C.3.e)	at least three months designated for research or other well-defined scholarly activity leading to new knowledge related to the required rotations. (Core)	4.11.e.	The curriculum must be structured to include at least three months designated for research or other well-defined scholarly activity leading to new knowledge related to the required rotations. (Core)
IV.C.4.	The didactic curriculum should be provided through lectures, conferences, facilitated self-learning, workshops, or simulation, and should supplement clinical experience. (Core)	4.11.f.	The didactic curriculum should be provided through lectures, conferences, facilitated self-learning, workshops, or simulation, and should supplement clinical experience. (Core)
IV.C.4.a)	Faculty members should be conference leaders in the majority of the sessions. (Core)	4.11.f.1.	Faculty members should be conference leaders in the majority of the sessions. (Core)
IV.C.4.b)	The didactic curriculum should include all topics listed as expected Medical Knowledge (see IV.B.1.c)) outcomes. (Core)	4.11.f.2.	The didactic curriculum should include all topics listed as expected Medical Knowledge (see 4.6.) outcomes. (Core)
IV.C.4.c)	Additional didactic topics must include:	4.11.f.3.	Additional didactic topics must include the impact of different anesthetic and analgesic techniques on health care resources, including room allocation, staffing, and patient throughput. (Core)
IV.C.4.c).(1)	the impact of different anesthetic and analgesic techniques on health care resources, including room allocation, staffing, and patient throughput; and, (Core)	4.11.f.3.	Additional didactic topics must include the impact of different anesthetic and analgesic techniques on health care resources, including room allocation, staffing, and patient throughput. (Core)
IV.C.4.c).(2)	sound business practices and the direct and indirect costs of different obstetric analgesic and anesthetic techniques. (Core)	4.11.f.4.	Additional didactic topics must include sound business practices and the direct and indirect costs of different obstetric analgesic and anesthetic techniques. (Core)
IV.C.5.	Clinical Experience Fellows' clinical experience must include:	4.11.g.	Clinical Experience Fellows' clinical experience must include a minimum of 30 high-risk maternal co-morbidity vaginal deliveries. (Core)
IV.C.5.a)	a minimum of 30 high-risk maternal co-morbidity vaginal deliveries; (Core)	4.11.g.	Clinical Experience Fellows' clinical experience must include a minimum of 30 high-risk maternal co-morbidity vaginal deliveries. (Core)

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IV.C.5.b)	a minimum of 30 high-risk fetal condition vaginal deliveries; (Core)	4.11.h.	Fellows' clinical experience must include a minimum of 30 high-risk fetal condition vaginal deliveries. (Core)
IV.C.5.c)	a minimum of 30 high-risk maternal co-morbidity Cesarean deliveries; (Core)	4.11.i.	Fellows' clinical experience must include a minimum of 30 high-risk maternal co-morbidity Cesarean deliveries. (Core)
IV.C.5.d)	a minimum of 20 high-risk fetal condition Cesarean deliveries; (Core)	4.11.j.	Fellows' clinical experience must include a minimum of 20 high-risk fetal condition Cesarean deliveries. (Core)
IV.C.5.e)	a minimum of 10 antenatal procedures, with no more than five cases accrued from cervical cerclage placement or removal; (Core)	4.11.k.	Fellows' clinical experience must include a minimum of 10 antenatal procedures, with no more than five cases accrued from cervical cerclage placement or removal. (Core)
IV.C.5.f)	a minimum of 20 ultrasonography procedures; (Core)	4.11.l.	Fellows' clinical experience must include a minimum of 20 ultrasonography procedures. (Core)
IV.C.5.g)	a minimum of 20 neuraxial ultrasound exams, including at least five abdominal plane blocks (e.g., transversus abdominis, quadratus lumborum); (Core)	4.11.m.	Fellows' clinical experience must include a minimum of 20 neuraxial ultrasound exams, including at least five abdominal plane blocks (e.g., transversus abdominis, quadratus lumborum). (Core)
IV.C.5.h)	evaluation and management of a minimum of five patients with postpartum headache; and, (Core).	4.11.n.	Fellows' clinical experience must include evaluation and management of a minimum of five patients with postpartum headache. (Core).
IV.C.5.i)	a minimum of 10 neonatal resuscitations, with the support of a skilled neonatology team. (Core)	4.11.o.	Fellows' clinical experience must include a minimum of 10 neonatal resuscitations, with the support of a skilled neonatology team. (Core)
IV.D.	**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 diversity 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.***	**[None]**	**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 diversity 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.***
IV.D.1.	**Program Responsibilities**	**4.13.**	**Program Responsibilities** **The program must demonstrate evidence of scholarly activities, consistent with its mission(s) and aims. (Core)**
IV.D.1.a)	**The program must demonstrate evidence of scholarly activities, consistent with its mission(s) and aims. (Core)**	**4.13.**	**Program Responsibilities** **The program must demonstrate evidence of scholarly activities, consistent with its mission(s) and aims. (Core)**

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IV.D.1.a).(1)	The program must provide instruction in the fundamentals of research design and conduct, and the interpretation and presentation of data. (Core)	4.13.b.	The program must provide instruction in the fundamentals of research design and conduct, and the interpretation and presentation of data. (Core)
IV.D.1.a).(2)	The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)	4.13.c.	The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)
IV.D.1.b)	**The program in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate fellow and faculty involvement in scholarly activities. (Core)**	**4.13.a.**	**The program in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate fellow and faculty involvement in scholarly activities. (Core)**
IV.D.2.	**Faculty Scholarly Activity**	**4.14.**	**Faculty Scholarly Activity** **Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)** **•Research in basic science, education, translational science, patient care, or population health** **•Peer-reviewed grants** **•Quality improvement and/or patient safety initiatives** **•Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports** **•Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials** **•Contribution to professional committees, educational organizations, or editorial boards** **•Innovations in education**
IV.D.2.a)	**Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)** **•Research in basic science, education, translational science, patient care, or population health** **•Peer-reviewed grants** **•Quality improvement and/or patient safety initiatives** **•Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports** **•Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials** **•Contribution to professional committees, educational organizations, or editorial boards** **•Innovations in education**	**4.14.**	**Faculty Scholarly Activity** **Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)** **•Research in basic science, education, translational science, patient care, or population health** **•Peer-reviewed grants** **•Quality improvement and/or patient safety initiatives** **•Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports** **•Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials** **•Contribution to professional committees, educational organizations, or editorial boards** **•Innovations in education**
IV.D.2.b)	**The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:**	**4.14.a.**	**The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:**
IV.D.2.b).(1)	**faculty 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 serving as a journal reviewer, journal editorial board member, or editor; (Outcome)**	**4.14.a.1.**	**faculty 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 serving as a journal reviewer, journal editorial board member, or editor; (Outcome)**
IV.D.2.b).(2)	**peer-reviewed publication. (Outcome)**	**4.14.a.2.**	**peer-reviewed publication. (Outcome)**

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IV.D.3.	**Fellow Scholarly Activity**	**4.15.**	**Fellow Scholarly Activity** Each fellow must conduct or be substantially involved in a scholarly project related to the subspecialty that is suitable for publication. (Core)
IV.D.3.a)	Each fellow must conduct or be substantially involved in a scholarly project related to the subspecialty that is suitable for publication. (Core)	**4.15.**	**Fellow Scholarly Activity** Each fellow must conduct or be substantially involved in a scholarly project related to the subspecialty that is suitable for publication. (Core)
IV.D.3.a).(1)	The results of such projects should be disseminated through a variety of means, including presentation at national or international meetings. (Core)	4.15.a.	The results of such projects should be disseminated through a variety of means, including presentation at national or international meetings. (Core)
IV.D.3.a).(2)	Fellows must have a faculty mentor overseeing their project. (Core)	4.15.b.	Fellows must have a faculty mentor overseeing their project. (Core)
V.	**Evaluation**	**Section 5**	**Section 5: Evaluation**
V.A.	**Fellow 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)**
V.A.1.	**Feedback and 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)**
V.A.1.a)	**Faculty members must directly observe, evaluate, and frequently provide feedback on fellow performance during each rotation or similar educational assignment. (Core)**	**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)**
V.A.1.a).(1)	Faculty members must provide evaluations of each fellow's progress and competence to the program director at the end of three, six, and nine months of education. (Core)	5.1.h.	Faculty members must provide evaluations of each fellow's progress and competence to the program director at the end of three, six, and nine months of education. (Core)
V.A.1.b)	**Evaluation must be documented at the completion of the assignment. (Core)**	**5.1.a.**	**Evaluation must be documented at the completion of the assignment. (Core)**
V.A.1.b).(1)	**For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)**	**5.1.a.1.**	**For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)**
V.A.1.b).(2)	**Longitudinal experiences such as continuity clinic in the context of other clinical responsibilities must be evaluated at least every three months and at completion. (Core)**	**5.1.a.2.**	**Longitudinal experiences such as continuity clinic in the context of other clinical responsibilities must be evaluated at least every three months and at completion. (Core)**
V.A.1.c)	**The program must provide an objective performance evaluation based on the Competencies and the subspecialty-specific Milestones, and must: (Core)**	**5.1.b.**	**The program must provide an objective performance evaluation based on the Competencies and the subspecialty-specific Milestones, and must: (Core)**
V.A.1.c).(1)	**use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)**	**5.1.b.1.**	**use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)**
V.A.1.c).(2)	**provide that information to the Clinical Competency Committee for its synthesis of progressive fellow performance and improvement toward unsupervised practice. (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)**
V.A.1.d)	**The program director or their designee, with input from the Clinical Competency Committee, must:**	**[None]**	

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V.A.1.d).(1)	meet with and review with each fellow their documented semi-annual evaluation of performance, including progress along the subspecialty-specific Milestones; (Core)	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)
V.A.1.d).(2)	assist fellows in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)	5.1.d.	The program director or their designee, with input from the Clinical Competency Committee, must assist fellows in developing individualized learning plans to capitalize on their strengths and identify areas for growth. (Core)
V.A.1.d).(3)	develop plans for fellows failing to progress, following institutional policies and procedures. (Core)	5.1.e.	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)
V.A.1.e)	At least annually, there must be a summative evaluation of each fellow that includes their readiness to progress to the next year of the program, if applicable. (Core)	5.1.f.	At least annually, there must be a summative evaluation of each fellow that includes their readiness to progress to the next year of the program, if applicable. (Core)
V.A.1.f)	The evaluations of a fellow's performance must be accessible for review by the fellow. (Core)	5.1.g.	The evaluations of a fellow's performance must be accessible for review by the fellow. (Core)
V.A.2.	Final Evaluation	5.2.	Fellow Evaluation: Final Evaluation The program director must provide a final evaluation for each fellow upon completion of the program. (Core)
V.A.2.a)	The program director must provide a final evaluation for each fellow upon completion of the program. (Core)	5.2.	Fellow Evaluation: Final Evaluation The program director must provide a final evaluation for each fellow upon completion of the program. (Core)
V.A.2.a).(1)	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.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)
V.A.2.a).(2)	The final evaluation must:	[None]	
V.A.2.a).(2).(a)	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.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)
V.A.2.a).(2).(b)	verify that the fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; and, (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)
V.A.2.a).(2).(c)	be shared with the fellow upon completion of the program. (Core)	5.2.d.	The final evaluation must be shared with the fellow upon completion of the program. (Core)
V.A.3.	A Clinical Competency Committee must be appointed by the program director. (Core)	5.3.	Clinical Competency Committee A Clinical Competency Committee must be appointed by the program director. (Core)
V.A.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)	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)
V.A.3.b)	The Clinical Competency Committee must:	[None]	
V.A.3.b).(1)	review all fellow evaluations at least semi-annually; (Core)	5.3.b.	The Clinical Competency Committee must review all fellow evaluations at least semi-annually. (Core)

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V.A.3.b).(2)	determine each fellow's progress on achievement of the subspecialty-specific Milestones; and, (Core)	5.3.c.	The Clinical Competency Committee must determine each fellow's progress on achievement of the subspecialty-specific Milestones. (Core)
V.A.3.b).(3)	meet prior to the fellows' semi-annual evaluations and advise the program director regarding each fellow's progress. (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)
V.B.	Faculty Evaluation	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)
V.B.1.	The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (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)
V.B.1.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.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)
V.B.1.b)	This evaluation must include written, confidential evaluations by the fellows. (Core)	5.4.b.	This evaluation must include written, confidential evaluations by the fellows. (Core)
V.B.2.	Faculty members must receive feedback on their evaluations at least annually. (Core)	5.4.c.	Faculty members must receive feedback on their evaluations at least annually. (Core)
V.B.3.	Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)	5.4.d.	Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)
V.C.	Program Evaluation and Improvement	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)
V.C.1	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.	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)
V.C.1.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.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)
V.C.1.b)	Program Evaluation Committee responsibilities must include:	[None]	
V.C.1.b).(1)	review of the program's self-determined goals and progress toward meeting them; (Core)	5.5.b.	Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them. (Core)
V.C.1.b).(2)	guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)	5.5.c.	Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes. (Core)
V.C.1.b).(3)	review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (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)

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V.C.1.c)	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)	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)
V.C.1.d)	The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)	5.5.f.	The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)
V.C.1.e)	The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the fellows and the members of the teaching faculty, and be submitted to the DIO. (Core)	5.5.g.	The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the fellows and the members of the teaching faculty, and be submitted to the DIO. (Core)
V.C.2.	The program must participate in a Self-Study and submit it to the DIO. (Core)	5.5.h.	The program must participate in a Self-Study and submit it to the DIO. (Core)
VI.	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*	Section 6	Section 6: The Learning and Working Environment 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*
VI.A.	Patient Safety, Quality Improvement, Supervision, and Accountability	[None]	
VI.A.1.	Patient Safety and Quality Improvement	[None]	
VI.A.1.a)	Patient Safety	[None]	
VI.A.1.a).(1)	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.*	[None]	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.*
VI.A.1.a).(1).(a)	The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)	6.1.	The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

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VI.A.1.a).(2)	**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.***	[None]	**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.***
VI.A.1.a).(2).(a)	**Residents, fellows, faculty members, and other clinical staff members must:**	[None]	
VI.A.1.a).(2).(a).(i)	**know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events; and, (Core)**	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)**
VI.A.1.a).(2).(a).(ii)	**be provided with summary information of their institution's patient safety reports. (Core)**	6.2.a.	**Residents, fellows, faculty members, and other clinical staff members must be provided with summary information of their institution's patient safety reports. (Core)**
VI.A.1.a).(2).(b)	**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)**	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)**
VI.A.1.a).(3)	**Quality Metrics** ***Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.***	[None]	**Quality Metrics** ***Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.***
VI.A.1.a).(3).(a)	**Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)**	6.4.	**Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)**
VI.A.2.	**Supervision and Accountability**	[None]	**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.***

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VI.A.2.a)	***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.***	**[None]**	**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.***
VI.A.2.a).(1)	**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.**	**Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to fellows, faculty members, other members of the health care team, and patients. (Core)**
VI.A.2.a).(1).(a)	**This information must be available to fellows, faculty members, other members of the health care team, and patients. (Core)**	**6.5.**	**Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to fellows, faculty members, other members of the health care team, and patients. (Core)**
VI.A.2.a).(2)	**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.**	**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)**
VI.A.2.a).(2).(a)	The fellowship program must work together with the anesthesiology residency program to prepare and implement a supervision policy that specifies the lines of responsibility for the anesthesiology residents and the program's fellows. (Core)	6.6.a.	The fellowship program must work together with the anesthesiology residency program to prepare and implement a supervision policy that specifies the lines of responsibility for the anesthesiology residents and the program's fellows. (Core)
VI.A.2.b)	**Levels of Supervision** **To promote appropriate fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:**	**[None]**	**Levels of Supervision** ***To promote appropriate fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision.***
VI.A.2.b).(1)	**Direct Supervision:**	**6.7.**	**Direct Supervision** ***The supervising physician is physically present with the fellow during the key portions of the patient interaction.***
VI.A.2.b).(1).(a)	**the supervising physician is physically present with the fellow during the key portions of the patient interaction; or,**	**6.7.**	**Direct Supervision** ***The supervising physician is physically present with the fellow during the key portions of the patient interaction.***
VI.A.2.b).(2)	**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.**	**[None]**	**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.***

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VI.A.2.b).(3)	Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.	[None]	Oversight *The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.*
VI.A.2.c)	The program must define when physical presence of a supervising physician is required. (Core)	6.8.	The program must define when physical presence of a supervising physician is required. (Core)
VI.A.2.d)	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.	The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. (Core)
VI.A.2.d).(1)	The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones. (Core)	6.9.a.	The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones. (Core)
VI.A.2.d).(2)	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.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)
VI.A.2.d).(3)	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)	6.9.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)
VI.A.2.e)	Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s). (Core)	6.10.	Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s). (Core)
VI.A.2.e).(1)	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)	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)
VI.A.2.f)	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)	6.11.	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)
VI.B.	Professionalism	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)
VI.B.1.	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)	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)
VI.B.2.	The learning objectives of the program must:	[None]	
VI.B.2.a)	be accomplished without excessive reliance on fellows to fulfill non-physician obligations; (Core)	6.12.a.	The learning objectives of the program must be accomplished without excessive reliance on fellows to fulfill non-physician obligations. (Core)
VI.B.2.b)	ensure manageable patient care responsibilities; and, (Core)	6.12.b.	The learning objectives of the program must ensure manageable patient care responsibilities. (Core)

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VI.B.2.c)	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.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)
VI.B.3.	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.	The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)
VI.B.4.	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.	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)
VI.B.5.	Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, 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)	6.12.f.	Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, 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)
VI.B.6.	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)	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)
VI.C.	**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.***	[None]	**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.***
VI.C.1.	The responsibility of the program, in partnership with the Sponsoring Institution, must include:	6.13.	The responsibility of the program, in partnership with the Sponsoring Institution, must include:
VI.C.1.a)	attention to scheduling, work intensity, and work compression that impacts fellow well-being; (Core)	6.13.a.	attention to scheduling, work intensity, and work compression that impacts fellow well-being; (Core)

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VI.C.1.b)	evaluating workplace safety data and addressing the safety of fellows and faculty members; (Core)	6.13.b.	evaluating workplace safety data and addressing the safety of fellows and faculty members; (Core)
VI.C.1.c)	policies and programs that encourage optimal fellow and faculty member well-being; and, (Core)	6.13.c.	policies and programs that encourage optimal fellow and faculty member well-being; and, (Core)
VI.C.1.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.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)
VI.C.1.d)	education of fellows and faculty members in:	6.13.d.	education of fellows and faculty members in:
VI.C.1.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)	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)
VI.C.1.d).(2)	recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)	6.13.d.2.	recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)
VI.C.1.d).(3)	access to appropriate tools for self-screening. (Core)	6.13.d.3.	access to appropriate tools for self-screening. (Core)
VI.C.1.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)	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)
VI.C.2.	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.	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)
VI.C.2.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.a.	The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)
VI.C.2.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)	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)
VI.D.	Fatigue Mitigation	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)
VI.D.1.	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)	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)
VI.D.2.	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)	6.16.	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)
VI.E.	Clinical Responsibilities, Teamwork, and Transitions of Care	[None]	
VI.E.1.	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)	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)

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VI.E.2.	**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)**	**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)**
VI.E.2.a)	Fellows must demonstrate the ability to work in a multidisciplinary environment, particularly the ability to have collegial and effective interactions with other members of the perinatal care team. (Outcome)	6.18.a.	Fellows must demonstrate the ability to work in a multidisciplinary environment, particularly the ability to have collegial and effective interactions with other members of the perinatal care team. (Outcome)
VI.E.3.	**Transitions of Care**	**6.19.**	**Transitions of Care** **Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)**
VI.E.3.a)	**Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)**	**6.19.**	**Transitions of Care** **Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)**
VI.E.3.b)	**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.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)**
VI.E.3.c)	**Programs must ensure that fellows are competent in communicating with team members in the hand-off process. (Outcome)**	**6.19.b.**	**Programs must ensure that fellows are competent in communicating with team members in the hand-off process. (Outcome)**
VI.F.	**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.**	**[None]**	**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.***
VI.F.1.	**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, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)**	**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, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)**
VI.F.2.	**Mandatory Time Free of Clinical Work and Education**	**6.21.**	**Mandatory Time Free of Clinical Work and Education** **Fellows should have eight hours off between scheduled clinical work and education periods. (Detail)**
VI.F.2.a)	**Fellows should have eight hours off between scheduled clinical work and education periods. (Detail)**	**6.21.**	**Mandatory Time Free of Clinical Work and Education** **Fellows should have eight hours off between scheduled clinical work and education periods. (Detail)**
VI.F.2.b)	**Fellows must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)**	**6.21.a.**	**Fellows must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)**
VI.F.2.c)	**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.**	**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)**
VI.F.3.	**Maximum Clinical Work and Education Period Length**	**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)**

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VI.F.3.a)	Clinical and educational work periods for fellows must not exceed 24 hours of continuous scheduled clinical assignments. (Core)	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)
VI.F.3.a).(1)	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.	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)
VI.F.4.	Clinical and Educational Work Hour Exceptions	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)
VI.F.4.a)	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.	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)
VI.F.4.b)	These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)	6.23.a.	These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)
VI.F.4.c)	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 Anesthesiology will not consider requests for exceptions to the 80-hour limit to the residents' work week.	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 Anesthesiology will not consider requests for exceptions to the 80-hour limit to the residents' work week.
VI.F.5.	Moonlighting	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)
VI.F.5.a)	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)	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)
VI.F.5.b)	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)	6.25.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)
VI.F.6.	In-House Night Float Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (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)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
VI.F.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)	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)
VI.F.8.	At-Home Call	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)
VI.F.8.a)	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)	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)
VI.F.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)	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)