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.***

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
Int.B.	**Definition of Subspecialty** Pain medicine is the discipline of medicine that specializes in the management of patients suffering from acute or chronic pain, or pain in patients requiring palliative care. The management of acute and chronic pain syndromes is a complex matter involving many areas of interest and different medical disciplines. Clinical and investigative efforts are vital to the progress of the specialty. Fellows may originate from different disciplines and approach the field with varying backgrounds and experience. All pain specialists, regardless of their primary specialty, should be competent in pain assessment, formulation, and coordination of a multiple modality treatment plan, integration of pain treatment with primary disease management and palliative care, and interaction with other members of a multidisciplinary team. Therefore, the didactic and clinical curriculum of the pain is designed to address attainment of these Competencies.	**[None]**	***Definition of Subspecialty*** *Pain medicine is the discipline of medicine that specializes in the management of patients suffering from acute or chronic pain, or pain in patients requiring palliative care. The management of acute and chronic pain syndromes is a complex matter involving many areas of interest and different medical disciplines. Clinical and investigative efforts are vital to the progress of the specialty. Fellows may originate from different disciplines and approach the field with varying backgrounds and experience. All pain specialists, regardless of their primary specialty, should be competent in pain assessment, formulation, and coordination of a multiple modality treatment plan, integration of pain treatment with primary disease management and palliative care, and interaction with other members of a multidisciplinary team. Therefore, the didactic and clinical curriculum of the pain is designed to address attainment of these Competencies.*
Int.C.	**Length of Educational Program** The educational program in pain medicine must be 12 months in length. (Core)	**4.1.**	**Length of Program** The educational program in pain medicine 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)	Only multidisciplinary programs will be accredited. A multidisciplinary program in pain medicine must be conducted in an institution and/or its participating sites that sponsor(s) ACGME-accredited residencies in at least one of the following specialties: anesthesiology; physical medicine and rehabilitation; and child neurology or neurology. (Core)	1.2.a.	Only multidisciplinary programs will be accredited. A multidisciplinary program in pain medicine must be conducted in an institution and/or its participating sites that sponsor(s) ACGME-accredited residencies in at least one of the following specialties: anesthesiology; physical medicine and rehabilitation; and child neurology or neurology. (Core)

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I.B.1.a).(1)	Programs must adequately demonstrate their commitment to the multidisciplinary nature of the specialty with applicable faculty member appointments. (Core)	1.2.a.1.	Programs must adequately demonstrate their commitment to the multidisciplinary nature of the specialty with applicable faculty member appointments. (Core)
I.B.1.b)	There must be an institutional policy governing the educational resources committed to pain medicine that ensures cooperation of all the involved disciplines. There must be a multidisciplinary fellowship committee to regularly review the program's resources and its attainment of stated goals and objectives. (Core)	1.2.b.	There must be an institutional policy governing the educational resources committed to pain medicine that ensures cooperation of all the involved disciplines. There must be a multidisciplinary fellowship committee to regularly review the program's resources and its attainment of stated goals and objectives. (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)**
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)**

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I.D.1.a)	Space and Equipment The following facilities and equipment must be available to the program: (Core)	1.8.a.	Space and Equipment The following facilities and equipment must be available to the program: (Core)
I.D.1.a).(1)	a pain center offering subspecialty education, designed specifically for the management of pain patients; and, (Core)	1.8.a.1.	a pain center offering subspecialty education, designed specifically for the management of pain patients; and, (Core)
I.D.1.a).(1).(a)	appropriate monitoring and life support equipment immediately available wherever invasive pain management procedures are performed. (Core)	1.8.a.2.	appropriate monitoring and life support equipment immediately available wherever invasive pain management procedures are performed. (Core)
I.D.1.a).(2)	Space for research and teaching conferences in pain medicine must be available. (Core)	1.8.b.	Space for research and teaching conferences in pain medicine must be available. (Core)
I.D.1.a).(3)	There must be appropriate on-call facilities for all fellows and faculty members. (Core)	1.8.c.	There must be appropriate on-call facilities for all fellows and faculty members. (Core)
I.D.1.b)	Support Services The following functions and support must be available:	1.8.d.	Support Services The following functions and support must be available:
I.D.1.b).(1)	appropriate radiologic imaging facilities; (Core)	1.8.d.1.	appropriate radiologic imaging facilities; (Core)
I.D.1.b).(2)	psychiatric/psychological services, including behavioral modification; (Core)	1.8.d.2.	psychiatric/psychological services, including behavioral modification; (Core)
I.D.1.b).(3)	physical and/or occupational therapy; (Core)	1.8.d.3.	physical and/or occupational therapy; (Core)
I.D.1.b).(4)	social services; and, (Core)	1.8.d.4.	social services; and, (Core)
I.D.1.b).(5)	appropriate electrodiagnostic facilities. (Core)	1.8.d.5.	appropriate electrodiagnostic facilities. (Core)
I.D.1.c)	Patient Population (Clinical Resources) There should be, within the patient population, a wide variety of clinical pain problems to allow fellows to develop broad clinical skills and knowledge required for a specialist in pain medicine. (Core)	1.8.e.	Patient Population (Clinical Resources) There should be, within the patient population, a wide variety of clinical pain problems to allow fellows to develop broad clinical skills and knowledge required for a specialist in pain medicine. (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)**
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)**

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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)**
II.A.2.a)	Program leadership, in aggregate, must be provided with support equal to a dedicated minimum time specified below for administration of the program. This may be time spent by the program director only or divided between the program director and one or more associate (or assistant) program directors. (Core) Number of Approved Fellow Positions: 1-2 | Minimum Support Required (FTE): 0.1 Number of Approved Fellow Positions: 3-5 |Minimum Support Required (FTE): 0.15 Number of Approved Fellow Positions: 6 or more | Minimum Support Required (FTE): 0.2	2.3.a.	Program leadership, in aggregate, must be provided with support equal to a dedicated minimum time specified below for administration of the program. This may be time spent by the program director only or divided between the program director and one or more associate (or assistant) program directors. (Core) Number of Approved Fellow Positions: 1-2 | Minimum Support Required (FTE): 0.1 Number of Approved Fellow Positions: 3-5 | Minimum Support Required (FTE): 0.15 Number of Approved Fellow Positions: 6 or more | Minimum Support Required (FTE): 0.2
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)**

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II.A.3.b)	**must include current certification in the subspecialty for which they are the program director by the American Board of** Anesthesiology, Physical Medicine and Rehabilitation, or Psychiatry and Neurology, **or by the American Osteopathic Board of** Anesthesiology, or a member board of the American Osteopathic Conjoint Pain Medicine Examination Committee, **or subspecialty qualifications that are acceptable to the Review Committee; and,. (Core)**	2.4.a.	**The program director must possess current certification in the subspecialty for which they are the program director by the American Board of** Anesthesiology, Physical Medicine and Rehabilitation, or Psychiatry and Neurology**, the American Osteopathic Board of** Anesthesiology, or a member board of the American Osteopathic Conjoint Pain Medicine Examination Committee, **or subspecialty qualifications that are acceptable to the Review Committee. (Core)**
II.A.3.c)	must include documentation of ongoing academic achievements appropriate to the subspecialty, including publications, the development of educational programs, or the conduct of research. (Core)	2.4.b.	The program director must have documentation of 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.A.4.a).(12)	**provide applicants who are offered an interview with information related to their eligibility for the relevant specialty board examination(s). (Core)**	**2.5.l.**	**The program director must provide applicants who are offered an interview with information related to their eligibility for the relevant specialty board examination(s). (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.1.a)	At least three faculty members with expertise in pain medicine, including the program director, must be involved in pain medicine subspecialty education, and these must equal at least two FTEs. (Core)	2.6.a.	At least three faculty members with expertise in pain medicine, including the program director, must be involved in pain medicine subspecialty education, and these must equal at least two FTEs. (Core)
II.B.1.b)	The faculty must include psychiatrists or clinical psychologists who have documented experience in the evaluation and treatment of patients with chronic pain. (Core)	2.6.b.	The faculty must include psychiatrists or clinical psychologists who have documented experience in the evaluation and treatment of patients with chronic pain. (Core)
II.B.2	**Faculty members must:**	**[None]**	

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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)**
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.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 subspecialty by the American Board of** Anesthesiology, Physical Medicine and Rehabilitation, **or Psychiatry and Neurology, or the American Osteopathic Board of** Anesthesiology, or a member board of the American Osteopathic Conjoint Pain Medicine Examination Committee, **or possess qualifications judged acceptable to the Review Committee. (Core)**	**2.9.**	**Subspecialty Physician Faculty Members** **Subspecialty physician faculty members must have current certification in the subspecialty by the American Board of** Anesthesiology, Physical Medicine and Rehabilitation, or Psychiatry and Neurology, **or the American Osteopathic Board of** Anesthesiology, or a member board of the American Osteopathic Conjoint Pain Medicine Examination Committee**, or possess qualifications judged acceptable to the Review Committee. (Core)**
II.B.3.b).(2)	The faculty as a whole must possess expertise across the domains of acute and chronic pain and pain in patients who require palliative care. (Core)	2.9.b.	The faculty as a whole must possess expertise across the domains of acute and chronic pain and pain in patients who require palliative care. (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.3.c).(1)	The faculty must include members who completed an ACGME-accredited or AOA-approved program in at least two of the following specialties: anesthesiology; physical medicine and rehabilitation; psychiatry; and child neurology or neurology. (Core)	2.9.a.1.	The faculty must include members who completed an ACGME-accredited or AOA-approved program in at least two of the following specialties: anesthesiology; physical medicine and rehabilitation; psychiatry; and child neurology or neurology. (Core)

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II.B.3.c).(1).(a)	These faculty members must have qualifications acceptable to the Review Committee. (Core)	2.9.a.1.a.	These faculty members must have qualifications 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)**
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 a ratio of at least one FTE core faculty member (salaried or non-salaried) to two fellows. (Core)	2.10.b.	There must be a ratio of at least one FTE core faculty member (salaried or non-salaried) to two fellows. (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)	At a minimum, the program coordinator must be supported at 20 percent FTE for administration of the program. Additional support must be provided based on 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: 5 | Minimum FTE Coordinator(s) Required: 0.28 Number of Approved Fellow Positions: > 5 | Minimum FTE Coordinator(s) Required: Additional 0.02 FTE per fellow	2.11.b.	At a minimum, the program coordinator must be supported at 20 percent FTE for administration of the program. Additional support must be provided based on 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: 5 | Minimum FTE Coordinator(s) Required: 0.28 Number of Approved Fellow Positions: > 5 | 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)**
III.	**Fellow Appointments**	**Section 3**	**Section 3: Fellow Appointments**
III.A.	**Eligibility Criteria**	**[None]**	

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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)**
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 programs, fellows should have completed a residency program that satisfies III.A.1. (Core)	3.2.a.1.	Prior to appointment in the programs, fellows should have completed a residency program that satisfies 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:	[None]	
IV.B.1.b).(1).(a).(i)	eliciting a detailed neurological history; (Core)	4.4.a.	Fellows must demonstrate competence in eliciting a detailed neurological history. (Core)
IV.B.1.b).(1).(a).(ii)	performing a detailed neurological examination to include at least mental status, cranial nerves, motor, sensory, reflex, cerebellum examinations, and gait in patients; (Core)	4.4.b.	Fellows must demonstrate competence in performing a detailed neurological examination to include at least mental status, cranial nerves, motor, sensory, reflex, cerebellum examinations, and gait in patients. (Core)
IV.B.1.b).(1).(a).(iii)	identifying significant findings of basic neuro-imaging; (Core)	4.4.c.	Fellows must demonstrate competence in identifying significant findings of basic neuro-imaging. (Core)
IV.B.1.b).(1).(a).(iii).(a)	Neuro-imaging studies must include at least magnetic resonance imaging (MRI) and computerized tomography (CT) of the spine and brain. (Core)	4.4.c.1.	Neuro-imaging studies must include at least magnetic resonance imaging (MRI) and computerized tomography (CT) of the spine and brain. (Core)
IV.B.1.b).(1).(a).(iii).(b)	Neuro-imaging studies must be drawn from the following areas: brain; cervical; thoracic; and lumbar spine. (Core)	4.4.c.2.	Neuro-imaging studies must be drawn from the following areas: brain; cervical; thoracic; and lumbar spine. (Core)
IV.B.1.b).(1).(a).(iii).(c)	Neuro-imaging study training must be verified by a faculty member from an ACGME-accredited residency program in child neurology/neurology, neurological surgery, or radiology, or by a faculty member with qualifications acceptable to the Review Committee. (Detail)	4.4.c.3.	Neuro-imaging study training must be verified by a faculty member from an ACGME-accredited residency program in child neurology/neurology, neurological surgery, or radiology, or by a faculty member with qualifications acceptable to the Review Committee. (Detail)

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IV.B.1.b).(1).(a).(iv)	performing a comprehensive musculoskeletal and appropriate neuromuscular history and examination with emphasis on both structure and function as it applies to diagnosing acute and chronic pain problems; (Core)	4.4.d.	Fellows must demonstrate competence in performing a comprehensive musculoskeletal and appropriate neuromuscular history and examination with emphasis on both structure and function as it applies to diagnosing acute and chronic pain problems. (Core)
IV.B.1.b).(1).(a).(v)	identifying and prescribing rehabilitation interventions for specific spine and musculoskeletal conditions; (Core)	4.4.e.	Fellows must demonstrate competence in identifying and prescribing rehabilitation interventions for specific spine and musculoskeletal conditions. (Core)
IV.B.1.b).(1).(a).(vi)	developing patient rehabilitation programs to include assessments of static and dynamic flexibility, strength, coordination, and agility for peripheral joint, spinal, and soft tissue pain conditions; including: (Core)	4.4.f.	Fellows must demonstrate competence in developing patient rehabilitation programs to include assessments of static and dynamic flexibility, strength, coordination, and agility for peripheral joint, spinal, and soft tissue pain conditions; including proficiency in the clinical evaluation and development of a rehabilitation plan. (Core)
IV.B.1.b).(1).(a).(vi).(a)	proficiency in the clinical evaluation and development of a rehabilitation plan. (Core)	4.4.f.	Fellows must demonstrate competence in developing patient rehabilitation programs to include assessments of static and dynamic flexibility, strength, coordination, and agility for peripheral joint, spinal, and soft tissue pain conditions; including proficiency in the clinical evaluation and development of a rehabilitation plan. (Core)
IV.B.1.b).(1).(a).(vii)	identifying patients best suited for multidisciplinary team pain management, to include patients with psychiatric and psychosocial risk factors and designing patient-specific programs in these situations; (Core)	4.4.g.	Fellows must demonstrate competence in identifying patients best suited for multidisciplinary team pain management, to include patients with psychiatric and psychosocial risk factors and designing patient-specific programs in these situations. (Core)
IV.B.1.b).(1).(a).(viii)	integrating therapeutic modalities and surgical intervention in the treatment algorithm; (Core)	4.4.h.	Fellows must demonstrate competence in integrating therapeutic modalities and surgical intervention in the treatment algorithm. (Core)
IV.B.1.b).(1).(a).(ix)	carrying out a complete and detailed psychiatric history with special attention to psychiatric and pain comorbidities; (Core)	4.4.i.	Fellows must demonstrate competence in carrying out a complete and detailed psychiatric history with special attention to psychiatric and pain comorbidities. (Core)
IV.B.1.b).(1).(a).(x)	conducting a complete mental status examination; and, (Core)	4.4.j.	Fellows must demonstrate competence in conducting a complete mental status examination. (Core)
IV.B.1.b).(1).(a).(xi)	explaining psychosocial therapy to a patient and making a referral when indicated. (Core)	4.4.k.	Fellows must demonstrate competence in explaining psychosocial therapy to a patient and making a referral when indicated. (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:	[None]	
IV.B.1.b).(2).(a).(i)	obtaining intravenous access; (Core)	4.5.a.	Fellows must demonstrate competence in obtaining intravenous access. (Core)
IV.B.1.b).(2).(a).(ii)	basic airway management that at a minimum includes competency in mask ventilation; (Core)	4.5.b.	Fellows must demonstrate competence in basic airway management that at a minimum includes competency in mask ventilation. (Core)

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IV.B.1.b).(2).(a).(iii)	advanced airway management; (Core)	4.5.c.	Fellows must demonstrate competence in advanced airway management. (Core)
IV.B.1.b).(2).(a).(iii).(a)	This must include experience with laryngeal mask airway and/or endotracheal intubation as a back-up if mask ventilation is unsuccessful. (Core)	4.5.c.1.	This must include experience with laryngeal mask airway and/or endotracheal intubation as a back-up if mask ventilation is unsuccessful. (Core)
IV.B.1.b).(2).(a).(iv)	basic life support and advanced cardiac life support; (Core)	4.5.d.	Fellows must demonstrate competence in basic life support and advanced cardiac life support. (Core)
IV.B.1.b).(2).(a).(v)	management of sedation, including exposure to administration of moderate procedural sedation; (Core)	4.5.e.	Fellows must demonstrate competence in management of sedation, including exposure to administration of moderate procedural sedation. (Core)
IV.B.1.b).(2).(a).(vi)	recognizing and managing physiologic perturbations associated with neuraxial anesthesia/analgesia, including development of motor and sensory loss and cardiovascular and respiratory changes; (Core)	4.5.f.	Fellows must demonstrate competence in recognizing and managing physiologic perturbations associated with neuraxial anesthesia/analgesia, including development of motor and sensory loss and cardiovascular and respiratory changes. (Core)
IV.B.1.b).(2).(a).(vii)	recognizing and managing physiologic perturbations associated with intravascular injection of local anesthetics, including mental status changes, seizure, and cardiovascular collapse; (Core)	4.5.g.	Fellows must demonstrate competence in recognizing and managing physiologic perturbations associated with intravascular injection of local anesthetics, including mental status changes, seizure, and cardiovascular collapse. (Core)
IV.B.1.b).(2).(a).(viii)	performing interventional treatments, including: (Core).	4.5.h.	Fellows must demonstrate competence in performing interventional treatments, including: (Core).
IV.B.1.b).(2).(a).(viii).(a)	epidural injections, to include interlaminar, transforaminal, and caudal; (Detail)	4.5.h.1.	epidural injections, to include interlaminar, transforaminal, and caudal; (Detail)
IV.B.1.b).(2).(a).(viii).(b)	trigger point injections; (Detail)	4.5.h.2.	trigger point injections; (Detail)
IV.B.1.b).(2).(a).(viii).(c)	facet and medial branch blocks; (Detail)	4.5.h.3.	facet and medial branch blocks; (Detail)
IV.B.1.b).(2).(a).(viii).(d)	neuroablative procedures; (Detail)	4.5.h.4.	neuroablative procedures; (Detail)
IV.B.1.b).(2).(a).(viii).(e)	joint and bursa injections; (Detail)	4.5.h.5.	joint and bursa injections; (Detail)
IV.B.1.b).(2).(a).(viii).(f)	sympathetic blocks; (Detail)	4.5.h.6.	sympathetic blocks; (Detail)
IV.B.1.b).(2).(a).(viii).(g)	peripheral nerve blocks; and, (Detail)	4.5.h.7.	peripheral nerve blocks; and, (Detail)
IV.B.1.b).(2).(a).(viii).(h)	understanding psychosocial risk factors that contraindicate permanent interventional procedures in patients with chronic pain. (Core)	4.5.h.8.	understanding psychosocial risk factors that contraindicate permanent interventional procedures in patients with chronic pain. (Core)
IV.B.1.b).(2).(a).(ix)	a range of direct, hands-on interventional pain treatment techniques; (Core)	4.5.i.	Fellows must demonstrate competence in a range of direct, hands-on interventional pain treatment techniques. (Core)
IV.B.1.b).(2).(a).(x)	neuromodulation and managing intervertebral disc procedures (e.g., spinal cord stimulation, peripheral nerve stimulation, electrical stimulation, and targeted drug delivery); and, (Detail)	4.5.j.	Fellows must demonstrate competence in neuromodulation and managing intervertebral disc procedures (e.g., spinal cord stimulation, peripheral nerve stimulation, electrical stimulation, and targeted drug delivery). (Detail)
IV.B.1.b).(2).(a).(xi)	interventional procedures and processes, including the following management skills: (Core)	4.5.k.	Fellows must demonstrate competence in interventional procedures and processes, including the following management skills: (Core)

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IV.B.1.b).(2).(a).(xi).(a)	recognizing risks and complications; (Detail)	4.5.k.1.	recognizing risks and complications; (Detail)
IV.B.1.b).(2).(a).(xi).(b)	obtaining a complete informed consent identifying the appropriate risks and potential benefits of each procedure, including sedation; (Detail)	4.5.k.2.	obtaining a complete informed consent identifying the appropriate risks and potential benefits of each procedure, including sedation; (Detail)
IV.B.1.b).(2).(a).(xi).(c)	identifying and mitigating risks for the following intervening factors: infection risk, opioid use, including the use of antagonists, anti-coagulation, pacemaker, and other implanted devices; and, (Detail)	4.5.k.3.	identifying and mitigating risks for the following intervening factors: infection risk, opioid use, including the use of antagonists, anti-coagulation, pacemaker, and other implanted devices; and, (Detail)
IV.B.1.b).(2).(a).(xi).(d)	managing patients receiving opioids, including an understanding of opioid agreements, risk mitigation tools, and appropriate use of drug screening. (Core)	4.5.k.4.	managing patients receiving opioids, including an understanding of opioid agreements, risk mitigation tools, and appropriate use of drug screening. (Core)
IV.B.1.b).(2).(b)	Fellows must demonstrate competence in:	[None]	
IV.B.1.b).(2).(b).(i)	recognizing substance use disorders, including associated stigma; and, (Detail)	4.5.l.	Fellows must demonstrate competence in recognizing substance use disorders, including associated stigma. (Detail)
IV.B.1.b).(2).(b).(ii)	identifying and implementing treatment options for substance use disorder, including medication-assisted treatment for Opioid Use Disorder. (Detail)	4.5.m.	Fellows must demonstrate competence in identifying and implementing treatment options for substance use disorder, including medication-assisted treatment for Opioid Use Disorder. (Detail)
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 competence in their knowledge of: (Core)	[None]	
IV.B.1.c).(1).(a)	assessment of pain, including: (Core)	4.6.a.	Fellows must demonstrate competence in their knowledge of assessment of pain, including: (Core)
IV.B.1.c).(1).(a).(i)	anatomy, physiology, and pharmacology of pain transmission and modulation; (Core)	4.6.a.1.	anatomy, physiology, and pharmacology of pain transmission and modulation; (Core)
IV.B.1.c).(1).(a).(ii)	natural history of various musculoskeletal pain disorders; (Core)	4.6.a.2.	natural history of various musculoskeletal pain disorders; (Core)
IV.B.1.c).(1).(a).(iii)	general principles of pain evaluation and management, to include neurological exam, musculoskeletal exam, and psychological assessment; (Core)	4.6.a.3.	general principles of pain evaluation and management, to include neurological exam, musculoskeletal exam, and psychological assessment; (Core)
IV.B.1.c).(1).(a).(iv)	indicators and interpretation of electro-diagnostic studies, to include: X-Rays; MRI; CT; and clinical nerve function studies; (Core)	4.6.a.4.	indicators and interpretation of electro-diagnostic studies, to include: X-Rays; MRI; CT; and clinical nerve function studies; (Core)
IV.B.1.c).(1).(a).(v)	pain measurement in humans, both experimental and clinical; (Core)	4.6.a.5.	pain measurement in humans, both experimental and clinical; (Core)
IV.B.1.c).(1).(a).(vi)	psychosocial aspects of pain, to include cultural and cross-cultural considerations; (Core)	4.6.a.6.	psychosocial aspects of pain, to include cultural and cross-cultural considerations; (Core)
IV.B.1.c).(1).(a).(vii)	taxonomy of pain syndromes; (Core)	4.6.a.7.	taxonomy of pain syndromes; (Core)
IV.B.1.c).(1).(a).(viii)	pain of spinal origin, to include radicular pain, zygapophysial joint disease, and discogenic pain; (Core)	4.6.a.8.	pain of spinal origin, to include radicular pain, zygapophysial joint disease, and discogenic pain; (Core)
IV.B.1.c).(1).(a).(ix)	myofascial pain; (Core)	4.6.a.9.	myofascial pain; (Core)
IV.B.1.c).(1).(a).(x)	neuropathic pain; (Core)	4.6.a.10.	neuropathic pain; (Core)
IV.B.1.c).(1).(a).(xi)	headache and orofacial pain; (Core)	4.6.a.11.	headache and orofacial pain; (Core)
IV.B.1.c).(1).(a).(xii)	rheumatological aspects of pain; (Core)	4.6.a.12.	rheumatological aspects of pain; (Core)

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IV.B.1.c).(1).(a).(xiii)	complex regional pain syndromes; (Core)	4.6.a.13.	complex regional pain syndromes; (Core)
IV.B.1.c).(1).(a).(xiv)	visceral pain; (Core)	4.6.a.14.	visceral pain; (Core)
IV.B.1.c).(1).(a).(xv)	urogenital pain; (Core)	4.6.a.15.	urogenital pain; (Core)
IV.B.1.c).(1).(a).(xvi)	cancer pain, including palliative and hospice care; (Core)	4.6.a.16.	cancer pain, including palliative and hospice care; (Core)
IV.B.1.c).(1).(a).(xvii)	acute pain; (Core)	4.6.a.17.	acute pain; (Core)
IV.B.1.c).(1).(a).(xviii)	frequent psychiatric and pain co-morbidities, to include substance-related mood, anxiety, somatoform, factitious, and personality disorders; (Core)	4.6.a.18.	frequent psychiatric and pain co-morbidities, to include substance-related mood, anxiety, somatoform, factitious, and personality disorders; (Core)
IV.B.1.c).(1).(a).(xix)	the effects of pain medications on mental status; (Core)	4.6.a.19.	the effects of pain medications on mental status; (Core)
IV.B.1.c).(1).(a).(xx)	assessment of pain in special populations, to include patients with ongoing substance use disorders, the elderly, pediatric patients, pregnant women, the physically disabled, and the cognitively impaired; and, (Core)	4.6.a.20.	assessment of pain in special populations, to include patients with ongoing substance use disorders, the elderly, pediatric patients, pregnant women, the physically disabled, and the cognitively impaired; and, (Core)
IV.B.1.c).(1).(a).(xxi)	functional and disability assessment. (Core)	4.6.a.21.	functional and disability assessment. (Core)
IV.B.1.c).(1).(b)	treatment of pain, including: (Core)	4.6.b.	Fellows must demonstrate competence in their knowledge of treatment of pain, including: (Core)
IV.B.1.c).(1).(b).(i)	drug treatment with:	[None]	
IV.B.1.c).(1).(b).(i).(a)	antidepressants, anticonvulsants, and miscellaneous drugs; (Core)	4.6.b.1.	drug treatment with antidepressants, anticonvulsants, and miscellaneous drugs; (Core)
IV.B.1.c).(1).(b).(i).(b)	nonsteroidal anti-inflammatory drugs; and, (Core)	4.6.b.2.	drug treatment with nonsteroidal anti-inflammatory drugs; (Core)
IV.B.1.c).(1).(b).(i).(c)	opioids. (Core)	4.6.b.3.	drug treatment with opioids; (Core)
IV.B.1.c).(1).(b).(ii)	systemic opioids, to include: (Core)	[None]	
IV.B.1.c).(1).(b).(ii).(a)	management of acute or chronic pain in the opioid tolerant patient; (Core)	4.6.b.4.	systemic opioids, to include management of acute or chronic pain in the opioid tolerant patient; (Core)
IV.B.1.c).(1).(b).(ii).(b)	pharmacokinetics of opioid analgesics, including bioavailability, absorption, distribution, metabolism, and excretion; (Core)	4.6.b.5.	systemic opioids, to include pharmacokinetics of opioid analgesics, including bioavailability, absorption, distribution, metabolism, and excretion; (Core)
IV.B.1.c).(1).(b).(ii).(c)	mechanism of action; (Core)	4.6.b.6.	systemic opioids, to include mechanism of action; (Core)
IV.B.1.c).(1).(b).(ii).(d)	chemical structure; (Core)	4.6.b.7.	systemic opioids, to include chemical structure; (Core)
IV.B.1.c).(1).(b).(ii).(e)	mechanisms, uses, and contraindications for opioid agonists, opioid antagonists, and mixed agents; (Core)	4.6.b.8.	systemic opioids, to include mechanisms, uses, and contraindications for opioid agonists, opioid antagonists, and mixed agents; (Core)
IV.B.1.c).(1).(b).(ii).(f)	use of patient controlled-analgesic systems; and, (Core)	4.6.b.9.	systemic opioids, to include use of patient controlled-analgesic systems; (Core)
IV.B.1.c).(1).(b).(ii).(g)	post-procedure analgesic management in the patient with chronic pain and/or opioid-induced hyperalgesia. (Core)	4.6.b.10.	systemic opioids, to include post-procedure analgesic management in the patient with chronic pain and/or opioid-induced hyperalgesia; (Core)

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IV.B.1.c).(1).(b).(iii)	psychological and psychiatric approaches to treatment, including cognitive-behavioral therapy, psychosocial therapies, and treatment of psychiatric illness; (Core)	4.6.b.11.	psychological and psychiatric approaches to treatment, including cognitive-behavioral therapy, psychosocial therapies, and treatment of psychiatric illness; (Core)
IV.B.1.c).(1).(b).(iv)	prescription drug detoxification concepts; (Core)	4.6.b.12.	prescription drug detoxification concepts; (Core)
IV.B.1.c).(1).(b).(v)	functional and vocational rehabilitation; (Core)	4.6.b.13.	functional and vocational rehabilitation; (Core)
IV.B.1.c).(1).(b).(vi)	surgical approaches; (Core)	4.6.b.14.	surgical approaches; (Core)
IV.B.1.c).(1).(b).(vii)	complementary and alternative treatments in pain management; (Core)	4.6.b.15.	complementary and alternative treatments in pain management; (Core)
IV.B.1.c).(1).(b).(viii)	treatments that comprise multidisciplinary cancer pain care; (Core)	4.6.b.16.	treatments that comprise multidisciplinary cancer pain care; (Core)
IV.B.1.c).(1).(b).(ix)	strategies to integrate pain management into the treatment model; (Core)	4.6.b.17.	strategies to integrate pain management into the treatment model; (Core)
IV.B.1.c).(1).(b).(x)	hospice and multidimensional treatments that comprise palliative care; and, (Core)	4.6.b.18.	hospice and multidimensional treatments that comprise palliative care; and, (Core)
IV.B.1.c).(1).(b).(xi)	treatment of pain in pediatric patients. (Core)	4.6.b.19.	treatment of pain in pediatric patients. (Core)
IV.B.1.c).(1).(c)	general topics, research, and ethics; including: (Core)	4.6.c.	Fellows must demonstrate competence in their knowledge of general topics, research, and ethics; including: (Core)
IV.B.1.c).(1).(c).(i)	epidemiology of pain; (Core)	4.6.c.1.	epidemiology of pain; (Core)
IV.B.1.c).(1).(c).(ii)	gender issues in pain; (Core)	4.6.c.2.	gender issues in pain; (Core)
IV.B.1.c).(1).(c).(iii)	placebo response; (Core)	4.6.c.3.	placebo response; (Core)
IV.B.1.c).(1).(c).(iv)	multidisciplinary pain medicine; (Core)	4.6.c.4.	multidisciplinary pain medicine; (Core)
IV.B.1.c).(1).(c).(v)	organization and management of a pain center; (Core)	4.6.c.5.	organization and management of a pain center; (Core)
IV.B.1.c).(1).(c).(vi)	utilization review and program evaluation; (Core)	4.6.c.6.	utilization review and program evaluation; (Core)
IV.B.1.c).(1).(c).(vii)	designing, reporting, and interpreting clinical trials of treatment for pain; (Core)	4.6.c.7.	designing, reporting, and interpreting clinical trials of treatment for pain; (Core)
IV.B.1.c).(1).(c).(viii)	ethical standards in pain management and research; and, (Core)	4.6.c.8.	ethical standards in pain management and research; and, (Core)
IV.B.1.c).(1).(c).(ix)	animal models of pain and ethics of animal experimentation. (Core)	4.6.c.9.	animal models of pain and ethics of animal experimentation. (Core)
IV.B.1.c).(1).(d)	interventional pain treatment, including: (Core)	4.6.d.	Fellows must demonstrate competence in their knowledge of interventional pain treatment, including: (Core)
IV.B.1.c).(1).(d).(i)	selection criteria for a broad range of interventions and an understanding of the indications and potential advantages and outcomes of these interventions; (Core)	4.6.d.1.	selection criteria for a broad range of interventions and an understanding of the indications and potential advantages and outcomes of these interventions; (Core)
IV.B.1.c).(1).(d).(ii)	airway management skills; (Core)	4.6.d.2.	airway management skills; (Core)
IV.B.1.c).(1).(d).(iii)	sedation/analgesia; (Core)	4.6.d.3.	sedation/analgesia; (Core)

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IV.B.1.c).(1).(d).(iv)	fluoroscopic imaging and radiation safety; (Core)	4.6.d.4.	fluoroscopic imaging and radiation safety; (Core)
IV.B.1.c).(1).(d).(v)	pharmacology of local anesthetics and other injectable medications, to include radiographic contrast agents and steroid preparations; (Core)	4.6.d.5.	pharmacology of local anesthetics and other injectable medications, to include radiographic contrast agents and steroid preparations; (Core)
IV.B.1.c).(1).(d).(v).(a)	This must include treatment of local anesthetic systemic toxicity. (Core)	4.6.d.5.a.	This must include treatment of local anesthetic systemic toxicity. (Core)
IV.B.1.c).(1).(d).(vi)	trigger point injections; (Core)	4.6.d.6.	trigger point injections; (Core)
IV.B.1.c).(1).(d).(vii)	peripheral and cranial nerve blocks and ablation; (Core)	4.6.d.7.	peripheral and cranial nerve blocks and ablation; (Core)
IV.B.1.c).(1).(d).(viii)	spinal injections, to include the following epidural injections: interlaminar; transforaminal; nerve root sheath injections; and zygapophysial joint injections; (Core)	4.6.d.8.	spinal injections, to include the following epidural injections: interlaminar; transforaminal; nerve root sheath injections; and zygapophysial joint injections; (Core)
IV.B.1.c).(1).(d).(ix)	discography and intradiscal/percutaneous disc treatments; (Core)	4.6.d.9.	discography and intradiscal/percutaneous disc treatments; (Core)
IV.B.1.c).(1).(d).(x)	joint and bursal injections, to include sacroiliac, hip, knee, and shoulder joint injections; (Core)	4.6.d.10.	joint and bursal injections, to include sacroiliac, hip, knee, and shoulder joint injections; (Core)
IV.B.1.c).(1).(d).(xi)	sympathetic ganglion blocks; (Core)	4.6.d.11.	sympathetic ganglion blocks; (Core)
IV.B.1.c).(1).(d).(xii)	epidural and intrathecal medication management; (Core)	4.6.d.12.	epidural and intrathecal medication management; (Core)
IV.B.1.c).(1).(d).(xiii)	spinal cord stimulation; and, (Core)	4.6.d.13.	spinal cord stimulation; and, (Core)
IV.B.1.c).(1).(d).(xiv)	intrathecal drug administration systems. (Core)	4.6.d.14.	intrathecal drug administration systems. (Core)
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)**

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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)**
IV.C.1.a)	Programs must provide each fellow with clinical experiences/rotations of sufficient duration and with sufficient continuity among supervising faculty that the progressive learning needed to support fellow development is not compromised. (Core)	4.10.a.	Programs must provide each fellow with clinical experiences/rotations of sufficient duration and with sufficient continuity among supervising faculty that the progressive learning needed to support fellow development is not compromised. (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.	Each fellow must have a distinct clinical experience in the following disciplines involved in pain medicine: anesthesiology, child neurology or neurology, physical medicine and rehabilitation, and psychiatry. Fellows do not require an experience in their primary discipline. (Core)	4.11.a.	Each fellow must have a distinct clinical experience in the following disciplines involved in pain medicine: anesthesiology, child neurology or neurology, physical medicine and rehabilitation, and psychiatry. Fellows do not require an experience in their primary discipline. (Core)

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IV.C.3.a)	Fellows must be provided with: (Core)	[None]	
IV.C.3.a).(1)	Outpatient (Continuity Clinic) Pain Experience (Core)	4.11.a.1.	Fellows must be provided with Outpatient (Continuity Clinic) Pain Experience. (Core)
IV.C.3.a).(1).(a)	Pain medicine fellows should attend a supervised outpatient clinic at least one half-day weekly when averaged throughout the year. (Core)	4.11.a.1.a.	Pain medicine fellows should attend a supervised outpatient clinic at least one half-day weekly when averaged throughout the year. (Core)
IV.C.3.a).(1).(b)	Fellows must have primary responsibility for 50 different patients followed over at least two months. (Core)	4.11.a.1.b.	Fellows must have primary responsibility for 50 different patients followed over at least two months. (Core)
IV.C.3.a).(1).(b).(i)	This experience should be documented. (Detail)	4.11.a.1.b.1.	This experience should be documented. (Detail)
IV.C.3.a).(2)	Inpatient Chronic Pain Experience (Core)	4.11.a.2.	Fellows must be provided with Inpatient Chronic Pain Experience. (Core)
IV.C.3.a).(2).(a)	Inpatient chronic pain experience should include assessment and management of inpatients with chronic pain. Fellows should see patients through a consultation team or on a designated inpatient pain medicine service. (Detail)	4.11.a.2.a.	Inpatient chronic pain experience should include assessment and management of inpatients with chronic pain. Fellows should see patients through a consultation team or on a designated inpatient pain medicine service. (Detail)
IV.C.3.a).(2).(a).(i)	This should include documented involvement with a minimum of 15 patients new to the fellow. (Detail)	4.11.a.2.a.1.	This should include documented involvement with a minimum of 15 patients new to the fellow. (Detail)
IV.C.3.a).(3)	Acute Pain Inpatient Experience (Core)	4.11.a.3.	Fellows must be provided with Acute Pain Inpatient Experience. (Core)
IV.C.3.a).(3).(a)	Acute pain inpatient experience should include supervised assessment and management of inpatients with acute pain. (Detail)	4.11.a.3.a.	Acute pain inpatient experience should include supervised assessment and management of inpatients with acute pain. (Detail)
IV.C.3.a).(3).(a).(i)	This should include documented involvement with a minimum of 50 patients new to the fellow. (Detail)	4.11.a.3.a.1.	This should include documented involvement with a minimum of 50 patients new to the fellow. (Detail)
IV.C.3.a).(4)	Cancer Pain (Core)	4.11.a.4.	Fellows must be provided with Cancer Pain Experience. (Core)
IV.C.3.a).(4).(a)	Cancer pain experience should be a supervised, longitudinal experience in an ambulatory or inpatient population that requires care for cancer pain, and may be integrated with continuity or inpatient experiences. (Detail)	4.11.a.4.a.	Cancer pain experience should be a supervised, longitudinal experience in an ambulatory or inpatient population that requires care for cancer pain, and may be integrated with continuity or inpatient experiences. (Detail)
IV.C.3.a).(5)	Palliative Care Experience (Core)	4.11.a.5.	Fellows must be provided with Palliative Care Experience. (Core)
IV.C.3.a).(5).(a)	Palliative care must be a supervised longitudinal experience in an ambulatory or inpatient population that requires palliative care, and may be integrated with continuity experience or inpatient experience. (Core)	4.11.a.5.a.	Palliative care must be a supervised longitudinal experience in an ambulatory or inpatient population that requires palliative care, and may be integrated with continuity experience or inpatient experience. (Core)
IV.C.3.b)	The didactic curriculum must be prepared by the program director, who, together with the faculty, must ensure: (Detail)	4.11.b.	The didactic curriculum must be prepared by the program director, who, together with the faculty, must ensure the curriculum complies with the written goals for the program. (Detail)
IV.C.3.b).(1)	the curriculum complies with the written goals for the program; and, (Detail)	4.11.b.	The didactic curriculum must be prepared by the program director, who, together with the faculty, must ensure the curriculum complies with the written goals for the program. (Detail)
IV.C.3.b).(2)	pain medicine conferences are held at least monthly. (Detail)	4.11.c.	The didactic curriculum must be prepared by the program director, who, together with the faculty, must ensure pain medicine conferences are held at least monthly. (Detail)
IV.C.3.b).(2).(a)	This should include morbidity and mortality conferences, journal reviews, and research seminars. (Detail)	4.11.c.1.	This should include morbidity and mortality conferences, journal reviews, and research seminars. (Detail)
IV.C.3.b).(2).(b)	There should be active participation in the planning and presentation of these conferences by fellows and faculty members. (Detail)	4.11.c.2.	There should be active participation in the planning and presentation of these conferences by fellows and faculty members. (Detail)

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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)**
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**

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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)**
IV.D.3.	**Fellow Scholarly Activity**	**4.15.**	**Fellow Scholarly Activity** All fellows must complete a scholarly project. (Core)
IV.D.3.a)	All fellows must complete a scholarly project. (Core)	**4.15.**	**Fellow Scholarly Activity** All fellows must complete a scholarly project. (Core)
IV.D.3.a).(1)	The results of such projects must be disseminated through a variety of means, including publication or presentation at local, regional, national, or international meetings. (Core)	4.15.a.	The results of such projects must be disseminated through a variety of means, including publication or presentation at local, regional, national, or international meetings. (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)**

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V.A.1.a).(1)	This should include evaluations of attitude, interpersonal relationship skills, fund of knowledge, manual skills, decision-making skills, and critical analysis of clinical situations. (Detail)	5.1.h.	Feedback on fellow performance should include evaluations of attitude, interpersonal relationship skills, fund of knowledge, manual skills, decision-making skills, and critical analysis of clinical situations. (Detail)
V.A.1.a).(2)	There must be periodic evaluation of patient care (quality assurance). (Detail)	5.1.i.	There must be periodic evaluation of patient care (quality assurance). (Detail)
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]**	
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)**

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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)
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)

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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)
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)

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V.C.3.	***One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.*** ***The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.***	**[None]**	**Board Certification** ***One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.*** ***The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.***
V.C.3.a)	**For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)**	**5.6.**	**Board Certification** **For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)**
V.C.3.b)	**For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)**	**5.6.a.**	**For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)**
V.C.3.c)	**For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)**	**5.6.b.**	**For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)**
V.C.3.d)	**For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)**	**5.6.c.**	**For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. (Outcome)**
V.C.3.e)	**For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that subspecialty. (Outcome)**	**5.6.d.**	**For each of the exams referenced in 5.6. – 5.6.c., any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that subspecialty. (Outcome)**
V.C.3.f)	**Programs must report, in ADS, board certification status annually for the cohort of board-eligible fellows that graduated seven years earlier. (Core)**	**5.6.e.**	**Programs must report, in ADS, board certification status annually for the cohort of board-eligible fellows that graduated seven years earlier. (Core)**

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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)**
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)**

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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.*
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)

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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.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.* *The supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.*
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.* *The supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.*
VI.A.2.b).(1).(b)	the supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.	6.7.	Direct Supervision *The supervising physician is physically present with the fellow during the key portions of the patient interaction.* *The supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.*
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)

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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)
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:

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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)
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)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
VI.E.1.a)	An optimal clinical workload allows fellows to complete the required case numbers and develop the required competencies in patient care with a focus on learning over meeting service obligations. (Detail)	6.17.a.	An optimal clinical workload allows fellows to complete the required case numbers and develop the required competencies in patient care with a focus on learning over meeting service obligations. (Detail)
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.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 Committees will not consider requests for exceptions to the 80-hour limit to the fellows' 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 Committees will not consider requests for exceptions to the 80-hour limit to the fellows' 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)

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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)