ACGME Program Requirements for Graduate Medical Education
in Regional Anesthesiology and Acute Pain Medicine
Summary and Impact of Major Requirement Revisions

Requirement #: **1.2.a.**

Requirement Revision (significant change only):

1.2.a. The Sponsoring Institution ~~must~~ should sponsor an ACGME-accredited anesthesiology residency. (~~Core~~Detail)

1. Describe the Review Committee's rationale for this revision:
   The Review Committee recognizes that regional anesthesiology and acute pain medicine fellowships could theoretically operate as independent subspecialties, and the Review Committee anticipates making approval decisions on a case-by-case basis.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   n/a

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   n/a

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **1.10.a.**
Requirement Revision (significant change only):

~~1.10.a. The presence of other learners or staff members must not interfere with the appointed fellows' education (Core).~~

1. Describe the Review Committee's rationale for this revision:
   This requirement is duplicative of Common Program Requirement 1.10., related to other learners and health care personnel.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   n/a

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   n/a

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **2.3.a.**

Requirement Revision (significant change only):

2.3.a. At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program. Additional support for program leadership must be provided as specified below. This additional support may be for the program director only or divided among the program director and one or more associate (or assistant) program directors.: (Core)

Number of Approved Fellow Positions	Minimum Support Required (FTE) for the Program Director	Minimum Additional Support Required (FTE) for Program Leadership	Total Minimum Program Leadership Support
1-3	0.1	0.025	0.125
4-6	0.15	0.05	0.2
7-9	0.2	0.1	0.3
10-14	0.2	0.15	0.35
15 and Over	0.2	0.2	0.4

~~2.3.b. At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program: (Core)~~

~~Number of Approved Fellow Positions~~	~~Minimum FTE~~
~~1-2~~	~~0.1~~
~~3~~	~~0.125~~
~~4~~	~~0.15~~
~~5~~	~~0.175~~
~~>5~~	~~0.2~~

1. Describe the Review Committee's rationale for this revision:
   The Review Committee has received a number of concerns related to insufficient dedicated time for the program director and leadership team. This proposal mirrors dedicated leadership time for other anesthesiology fellowship programs.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

It will improve fellow education by providing more protected time for the program director and leadership team.

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   The need for additional resources is a possibility if the program does not currently provide sufficient protected non-clinical administrative time for the program director and/or leadership team.

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **2.6.a.**

Requirement Revision (significant change only):

~~2.6.a. Physicians certified in critical care through a member board of the ABMS or AOA must be available for consultation and collaborative management of critically-ill patients who require care from the regional anesthesia and acute pain medicine team.~~ ~~(Core)~~

1. Describe the Review Committee's rationale for this revision:
   The Committee determined that this requirement is no longer necessary as a formal program requirement because critical care consultation and collaborative management are already standard practices within hospital systems and governed by institutional policies, independent of fellowship accreditation requirements. The existing institutional infrastructure ensures that critically ill patients receive appropriate multidisciplinary care, including involvement of critical care–trained physicians when clinically indicated. Retaining this requirement imposed an unnecessary accreditation burden and did not meaningfully influence fellows' educational experience, as fellows do not assume primary responsibility for managing critically ill patients within this context. The deletion aligns the requirements with the actual scope of practice and training objectives of regional anesthesiology and acute pain medicine fellowships.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   The deletion removes redundancy but does not change patient care workflows or the availability of critical care specialists. Institutions will continue to follow established practices to ensure safe, interdisciplinary care.

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

n/a

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **NEW 2.12.c.**

Requirement Revision (significant change only):

2.12.c Addiction medicine services and personnel must be available to support the program. (Core)

1. Describe the Review Committee's rationale for this revision:
   The Committee added this requirement to recognize the essential role of addiction medicine expertise in the comprehensive care of patients with acute and chronic pain. Regional anesthesiology and acute pain medicine teams frequently manage patients with opioid tolerance, opioid use disorder, or other substance use–related complexities. Access to addiction medicine services enhances safe, multimodal pain management and supports fellows' understanding of evidence-based approaches to treating patients with coexisting pain and addiction. The requirement ensures that programs have the necessary interdisciplinary resources to educate and train fellows in managing this patient population, which reflects current clinical practice and national standards for safe opioid stewardship.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   This requirement strengthens fellow education by ensuring exposure to specialists who can guide best practices in managing pain in the context of substance use disorders. Integration of addiction medicine enhances patient safety by promoting appropriate opioid prescribing, recognizing risk factors for misuse, and supporting coordinated care. It also improves patient care quality by ensuring that fellows learn to manage complex clinical scenarios with a multidisciplinary approach.

3. How will the proposed requirement or revision impact continuity of patient care?
   No negative impact is anticipated. Access to addiction medicine services typically supports continuity by facilitating coordinated treatment plans among pain management practitioners, addiction medicine practitioners, and other clinical teams.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Most institutions already maintain addiction medicine services as part of standard hospital practice. Programs without existing access may need to identify formal consultation pathways, but no major new infrastructure is anticipated. If the institution already provides these services, no additional resources are required.

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **4.4.a.**

Requirement Revision (significant change only):

4.4.a. ~~Fellows must demonstrate competence by following standards for patient care and established guidelines and procedures for patient safety, error reduction, and improved patient outcomes.~~ ~~(Core)~~

1. Describe the Review Committee's rationale for this revision:
   This requirement is duplicative with Common Program Requirement 4.4.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   n/a

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   n/a

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **4.4.b.-4.4.b.7.a.**

Requirement Revision (significant change only):

4.4.b. Fellows must demonstrate ~~the following~~ competencies in regional anesthesiology and acute pain medicine.~~:~~ (Core)

Specialty-Specific Background and Intent: Regional anesthesiology and acute pain medicine competencies include: performance of pre-operative patient evaluation and optimization of clinical status; performance of a detailed neurologic history and physical examination with particular attention to pre-existing neurologic deficits and their impact on the anesthetic plan; rational selection of regional anesthesia and/or post-operative analgesic techniques for specific clinical situations, including regional techniques, multimodal analgesia, integrative medicine, and opioid and non-opioid pharmacological management; selection of regional versus general anesthesia for various procedures and patients in regard to patient recovery, patient outcome, operating room efficiency, and cost of care; management of inadequate operative regional anesthesia and post-operative analgesic techniques, including the use of supplemental blockade, alternate approaches, and pharmacological intervention; skills and knowledge necessary to perform and to effectively teach a wide range of advanced practice block techniques, achieving a high success and low complication rate; and management of an acute pain medicine service.

~~4.4.b.1 performance of pre-operative patient evaluation and optimization of clinical status;~~ ~~(Core)~~

~~4.4.b.2 performance of a detailed neurologic history and physical examination with particular attention to pre-existing neurologic deficits and their impact on the anesthetic plan; (Core)~~

~~4.4.b.3 rational selection of regional anesthesia and/or post-operative analgesic techniques for specific clinical situations; (Core)~~

~~4.4.b.3.a. This must include regional techniques, multimodal analgesia, integrative medicine, and opioid and non-opioid pharmacological management. (Core)~~

~~4.4.b.4 selection of regional versus general anesthesia for various procedures and patients in regard to patient recovery, patient outcome, operating room efficiency, and cost of care; (Core)~~

~~4.4.b.5 management of inadequate operative regional anesthesia and post-operative analgesic techniques, including the use of supplemental blockade, alternate approaches, and pharmacological intervention; (Core)~~

~~4.4.b.6 skills and knowledge necessary to perform and to effectively teach a wide range of advanced practice block techniques, achieving a high success and low complication rate; and, (Core)~~

~~4.4.b.7 management of an acute pain medicine service. (Core)~~

~~4.4.b.7.a Patient management should include multimodal analgesic techniques, such as neuraxial and peripheral nerve catheters, local anesthetic and opioid infusions, and non-opioid analgesic adjuvants. (Detail)~~

1. Describe the Review Committee's rationale for this revision:
   The Review Committee determined that many of the existing requirements in this section are overly prescriptive and do not meaningfully influence accreditation decisions, as citations are rarely issued based on these specific elements. The Committee concluded that programs can meet educational goals through a variety of effective instructional methods and that prescribing detailed approaches limits program flexibility without improving the quality of education and training. To better support innovation and reduce unnecessary regulatory burden, the Committee is proposing removal of these granular requirements. Additional explanatory detail will be incorporated into the Specialty-Specific Background and Intent to provide programs with context and guidance regarding the expected scope of educational content, while avoiding prescriptive directives in the requirements themselves.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   n/a

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
n/a

5. How will the proposed revision impact other accredited programs?
n/a

Requirement #: **4.4.c.-4.4.c.5.**

Requirement Revision (significant change only):

4.4.c. Fellows must demonstrate ~~the following~~ competencies in acute pain medicine.~~:~~ (Core)

Specialty-Specific Background and Intent: Acute pain medicine competencies include understanding how the acute pain medicine service addresses surgical regional anesthesia techniques (as placed by the operating room (OR) anesthesiologist); understanding how the acute pain medicine service addresses the peri- operative use of analgesic techniques by the acute pain medicine service; understanding how the acute pain medicine service addresses the peri- operative management of acute pain medicine intervention; understanding how the acute pain medicine service addresses the peri- operative management of acute pain medicine intervention; understanding how the acute pain medicine service addresses the provision of acute pain medicine services directed toward the patient with chronic pain who is also experiencing acute pain; and understanding how the acute pain medicine service addresses the provision of acute pain management to select non-surgical patients, such as those with conditions known to cause acute pain.

~~4.4.c.1 understanding how the acute pain medicine service addresses surgical regional anesthesia techniques (as placed by the operating room (OR) anesthesiologist); (Core)~~

~~4.4.c.2 understanding how the acute pain medicine service addresses the peri- operative use of analgesic techniques by the acute pain medicine service; (Outcome)~~

~~4.4.c.3 understanding how the acute pain medicine service addresses the peri- operative management of acute pain medicine intervention; (Core)~~

~~4.4.c.4 understanding how the acute pain medicine service addresses the provision of acute pain medicine services directed toward the patient with chronic pain who is also experiencing acute pain; and, (Core)~~

~~4.4.c.5 understanding how the acute pain medicine service addresses the provision of acute pain management to select non-surgical patients, such as those with conditions known to cause acute pain. (Core)~~

1. Describe the Review Committee's rationale for this revision:
The Review Committee determined that many of the existing requirements in this section are overly prescriptive and do not meaningfully influence accreditation decisions, as citations are rarely issued based on these specific elements. The

Committee concluded that programs can meet educational goals through a variety of effective instructional methods and that prescribing detailed approaches limits program flexibility without improving the quality of education and training. To better support innovation and reduce unnecessary regulatory burden, the Committee is proposing removal of these granular requirements. Additional explanatory detail will be incorporated into the Specialty-Specific Background and Intent to provide programs with context and guidance regarding the expected scope of educational content, while avoiding prescriptive directives in the requirements themselves.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   n/a

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   n/a

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **4.6.a.-4.6.a.3.**

Requirement Revision (significant change only):

4.6.a. Fellows must demonstrate knowledge of anatomy and clinical pharmacology, including central neuraxial and peripheral nerve anatomy, to include~~:~~ anatomy of neural pathways, differences between motor and sensory nerves, and microanatomy of the nerve cell. (Core)

~~4.6.a.1. anatomy of neural pathways; (Core)~~

~~4.6.a.2. differences between motor and sensory nerves; and, (Core)~~

~~4.6.a.3 microanatomy of the nerve cell. (Core)~~

1. Describe the Review Committee's rationale for this revision:
   The Review Committee is proposing to subsume the multiple program requirements into 4.6.a.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   n/a

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   n/a

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **4.6.b.-4.6.f.8.e**.

Requirement Revision (significant change only):

4.6.b. Fellows must demonstrate knowledge of anatomy and clinical pharmacology, including local anesthetic pharmacology, neuraxial opioids, systemic opioids, and non-opioid analgesia. ~~to include the:~~ (Core)

Specialty-Specific Background and Intent: Demonstration of knowledge related to anatomy and clinical pharmacology includes mechanism of action, physicochemical properties, pharmacokinetics and pharmacodynamics, and appropriate dosing for single injection or continuous infusion; selection and dose of local anesthetics as indicated for specific surgical conditions and in different age groups from infants to adults; dosing, advantages, and disadvantages of local anesthetic adjuvants; and signs, symptoms, and treatment of local anesthetic systemic toxicity and neurotoxicity of local anesthetics.

Demonstration of knowledge of anatomy and clinical pharmacology related to neuraxial opioids includes indications/contraindications, mechanism of action, physicochemical properties, effective dosing, and duration of action; complications and adverse effects, including related monitoring, prevention, and therapy; and differentiation of intrathecal versus epidural administration relative to dose, effect, and adverse effects.

Demonstration of knowledge of anatomy and clinical pharmacology related to systemic opioids includes pharmacokinetics of opioid analgesics, including bioavailability, absorption, distribution, metabolism, and excretion; mechanism of action; chemical structure; mechanisms, uses, and contraindications for opioid agonists, opioid antagonists, mixed agents; use of patient controlled-analgesic systems; post-procedure analgesic management in the patient with chronic pain and/or opioid-induced hyperalgesia; and management of acute or chronic pain in the opioid tolerant patient.

Demonstration of knowledge of anatomy and clinical pharmacology related to non-opioid analgesia includes multimodal analgesia and its impact on recovery after surgery; and pharmacology of acetaminophen, NSAIDs, COX-2 inhibitors, N-methyl-D- aspartic acid antagonists, α-2 agonists, intravenous lidocaine infusion, and γ-aminobutyric acid-pentanoic agents and anticonvulsant drugs with respect to optimizing post-operative analgesia.

~~4.6.b.1. mechanism of action, physicochemical properties, pharmacokinetics and pharmacodynamics, and appropriate dosing for single injection or continuous infusion; (Core)~~

~~4.6.b.2. selection and dose of local anesthetics as indicated for specific surgical conditions and in different age groups from infants to adults; (Core)~~

~~4.6.b.3. dosing, advantages, and disadvantages of local anesthetic adjuvants; and, (Core)~~

~~4.6.b.4. signs, symptoms, and treatment of local anesthetic systemic toxicity and neurotoxicity of local anesthetics. (Core)~~

~~4.6.c. Fellows must demonstrate knowledge of anatomy and clinical pharmacology, including neuraxial opioids, to include: (Core)~~

~~4.6.c.1. indications/contraindications, mechanism of action, physicochemical properties, effective dosing, and duration of action; (Core)~~

~~4.6.c.2. complications and adverse effects, including related monitoring, prevention, and therapy; and, (Core)~~

~~4.6.c.3. differentiation of intrathecal versus epidural administration relative to dose, effect, and adverse effects. (Core)~~

~~4.6.d. Fellows must demonstrate knowledge of anatomy and clinical pharmacology, including systemic opioids, to include: (Core)~~

~~4.6.d.1. pharmacokinetics of opioid analgesics, including bioavailability, absorption, distribution, metabolism, and excretion; (Core)~~

~~4.6.d.2. mechanism of action; (Core)~~

~~4.6.d.3. chemical structure; (Core)~~

~~4.6.d.4. mechanisms, uses, and contraindications for opioid agonists, opioid antagonists, mixed agents (Core)~~

~~4.6.d.5. use of patient controlled analgesic systems; (Core)~~

~~4.6.d.6. post-procedure analgesic management in the patient with chronic pain and/or opioid-induced hyperalgesia; and, (Core)~~

~~4.6.d.7. management of acute or chronic pain in the opioid tolerant patient. (Core)~~

~~4.6.e. Fellows must demonstrate knowledge of anatomy and clinical pharmacology, including non-opioid analgesia, to include: (Core)~~

~~4.6.e.1. multimodal analgesia and its impact on recovery after surgery; and, (Core)~~

~~4.6.e.2. pharmacology of acetaminophen, NSAIDs, COX-2 inhibitors, N-methyl-D-aspartic acid antagonists, α-2 agonists, and γ-aminobutyric acid-pentanoic agents and anticonvulsant drugs with respect to optimizing post-operative analgesia. (Core)~~

1. Describe the Review Committee's rationale for this revision:
   The Review Committee determined that many of the existing requirements in this section are overly prescriptive and do not meaningfully influence accreditation decisions, as citations are rarely issued based on these specific elements. The Committee concluded that programs can meet educational goals through a variety of effective instructional methods and that prescribing detailed approaches limits program flexibility without improving the quality of education and training. To better support innovation and reduce unnecessary regulatory burden, the Committee is proposing removal of these granular requirements. Additional explanatory detail will be incorporated into the Specialty-Specific Background and Intent to provide programs with context and guidance regarding the expected scope of educational content, while avoiding prescriptive directives in the requirements themselves.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   n/a

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   n/a

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **4.6.f..4.6.f.8.e.**

Requirement Revision (significant change only):

4.6.f. Fellows must demonstrate knowledge of regional anesthesia techniques, including nerve localization techniques, spinal anesthesia, epidural anesthesia (lumbar and thoracic), upper and lower extremity nerve block, truncal block, intravenous regional anesthesia, and complications of regional anesthesia and acute pain medicine. ~~to include:~~ (Core

Specialty-Specific Background and Intent: Demonstration of knowledge of regional anesthesia techniques related to nerve localization techniques includes principles, operation, advantages, and limitations of the peripheral nerve stimulator to localize and anesthetize peripheral nerves; principles of paresthesia-seeking, perivascular, or transvascular approaches to nerve localization; and principles, operation, advantages, safety and limitations of ultrasound to localize and anesthetize peripheral nerves.

Demonstration of knowledge of regional anesthesia techniques related to spinal anesthesia includes anatomy of the neuraxis; indications, contraindications, adverse effects, complications, and management of spinal anesthesia; cardiovascular and pulmonary physiologic effects of spinal anesthesia; common mechanisms for failed spinal anesthesia; various local anesthetics for intrathecal use, including agents, dosage, surgical and total duration of action, and adjuvants; factors affecting intensity, extent, and duration of block, including patient position, dose, volume, and baricity of injectate; dural puncture headache, including symptoms, etiology, risk factors, and treatment; and advantages and disadvantages of continuous spinal anesthesia.

Demonstration of knowledge of regional anesthesia techniques related to epidural anesthesia (lumbar and thoracic) includes indications, contraindications, adverse effects, complications, and management of epidural anesthesia and analgesia; local anesthetics for epidural use, including agents, dosage, adjuvants, and duration of action; spinal and epidural anesthesia differences in reliability, latency, duration, and segmental limitations; value and techniques of test dosing to minimize complications of epidural anesthesia and analgesia; interpretation of the volume-segment relationship and the effect of patient age, including extremes of age, pregnancy, position, and site of injection on resultant block; combined spinal-epidural anesthesia, including advantages/disadvantages, dose requirements, complications, indications, and contraindications; outcome benefits of thoracic epidural analgesia for thoracic and abdominal surgery and thoracic trauma; and differentiation between thoracic epidural

anesthesia/ analgesia and lumbar epidural anesthesia/analgesia, including advantages/ disadvantages, dose requirements, complications, indications, and contraindications.

Demonstration of knowledge of regional anesthesia techniques related to upper extremity nerve block includes anatomy and sonoanatomy of the brachial plexus in relation to sensory and motor innervation; local anesthetics for brachial plexus block, including agents, dose, duration of action, and adjuvants; value and techniques of intravascular test dosing to minimize local anesthetic systemic toxicity associated with peripheral nerve block; differentiation between the various brachial plexus (or terminal nerve) block sites, including indications, contraindications, advantages, disadvantages, complications, and management specific to each; indications and technique for cervical plexus, suprascapular, or intercostobrachial block as unique blocks or supplements to brachial plexus block; and technical and non-technical aspects unique to brachial plexus perineural catheter placement and management.

Demonstration of knowledge of regional anesthesia techniques related to lower extremity nerve block includes anatomy and sonoanatomy of the lower extremity, including sciatic, femoral, lateral femoral cutaneous, and obturator nerves, as well as the adductor canal and lumbar plexus (psoas), and options for saphenous nerve blockade; local anesthetics for lower extremity block, including agents, dose, duration of action, and adjuvants; value and techniques of intravascular test dosing to minimize local anesthetic systemic toxicity associated with peripheral nerve block; differentiation between the various approaches to lower-extremity blockade, including indications/contraindications, side effects, complications, and management specific to each; and technical and non-technical aspects unique to lower extremity perineural catheter placement and management.

Demonstration of knowledge of regional anesthesia techniques related to truncal block includes anatomy for intercostal, paravertebral, ilioinguinal-hypogastric, rectus sheath, and transversus abdominis plane blocks; local anesthetics for truncal blockade: agents, dose, and duration of action; indications, contraindications, side effects, complications, safety, and management of truncal blockade; and technical and non-technical aspects unique to continuous truncal catheter placement and management.

Demonstration of knowledge of regional anesthesia techniques related to intravenous regional anesthesia includes mechanism of action, indications, contraindications, advantages and disadvantages, adverse effects, complications, and management of intravenous regional anesthesia (IVRA); and agents used for IVRA, including local anesthetic choice, dosage, and use of adjuvants.

Demonstration of knowledge of regional anesthesia techniques related to complications of regional anesthesia and acute pain medicine includes the diagnosis and management of hemorrhagic complications, including complications due to anticoagulant and thrombolytic medications with specific reference to published guidelines; infectious complications; neurological complications (including the interpretation of tests recommended following plexus/nerve injury, including electromyography, nerve conduction studies, somatosensory evoked potentials, and motor evoked potentials); complications due to medicines, to include local anesthetic systemic toxicity and opioid-induced respiratory depression; and other complications, to include pneumothorax.

~~4.6.f.1.a. principles, operation, advantages, and limitations of the peripheral nerve stimulator to localize and anesthetize peripheral nerves; (Core)~~

4.6.f.1.b. principles of paresthesia-seeking, perivascular, or transvascular approaches to nerve localization; and, (Core)

4.6.f.1.c. principles, operation, advantages, safety and limitations of ultrasound to localize and anesthetize peripheral nerves. (Core)

4.6.f.2. Fellows must demonstrate knowledge of regional anesthesia techniques, including spinal anesthesia, to include: (Core)

4.6.f.2.a. anatomy of the neuraxis; (Core)

4.6.f.2.b. indications, contraindications, adverse effects, complications, and management of spinal anesthesia; (Core)

4.6.f.2.c. cardiovascular and pulmonary physiologic effects of spinal anesthesia; (Core)

4.6.f.2.d. common mechanisms for failed spinal anesthesia; (Core)

4.6.f.2.e. various local anesthetics for intrathecal use, including agents, dosage, surgical and total duration of action, and adjuvants; (Core)

4.6.f.2.f. factors affecting intensity, extent, and duration of block, including patient position, dose, volume, and baricity of injectate; (Core)

4.6.f.2.g. dural puncture headache, including symptoms, etiology, risk factors, and treatment; and, (Core)

4.6.f.2.h. advantages and disadvantages of continuous spinal anesthesia. (Core)

4.6.f.3. Fellows must demonstrate knowledge of regional anesthesia techniques, including epidural anesthesia (lumbar and thoracic), to include: (Core)

4.6.f.3.a. indications, contraindications, adverse effects, complications, and management of epidural anesthesia and analgesia; (Core)

4.6.f.3.b. local anesthetics for epidural use, including agents, dosage, adjuvants, and duration of action; (Core)

4.6.f.3.c. spinal and epidural anesthesia differences in reliability, latency, duration, and segmental limitations; (Core)

4.6.f.3.d. value and techniques of test dosing to minimize complications of epidural anesthesia and analgesia; (Core)

4.6.f.3.e. interpretation of the volume-segment relationship and the effect of patient age, including extremes of age, pregnancy, position, and site of injection on resultant block; (Core)

4.6.f.3.f. combined spinal-epidural anesthesia, including advantages/disadvantages, dose requirements, complications, indications, and contraindications; (Core)

4.6.f.3.g. outcome benefits of thoracic epidural analgesia for thoracic and abdominal surgery and thoracic trauma; and, (Core)

4.6.f.3.h. differentiation between thoracic epidural anesthesia/analgesia and lumbar epidural anesthesia/analgesia, including advantages/disadvantages, dose requirements, complications, indications, and contraindications. (Core)

4.6.f.4. ~~Fellows must demonstrate knowledge of regional anesthesia techniques, including upper extremity nerve block, to include:~~ (Core)

4.6.f.4.a. ~~anatomy and sonoanatomy of the brachial plexus in relation to sensory and motor innervation;~~ (Core)

4.6.f.4.b. ~~local anesthetics for brachial plexus block, including agents, dose, duration of action, and adjuvants;~~ (Core)

4.6.f.4.c. ~~value and techniques of intravascular test dosing to minimize local anesthetic systemic toxicity associated with peripheral nerve block;~~ (Core)

4.6.f.4.d. ~~differentiation between the various brachial plexus (or terminal nerve) block sites, including indications, contraindications, advantages, disadvantages, complications, and management specific to each;~~ (Core)

4.6.f.4.e. ~~indications and technique for cervical plexus, suprascapular, or intercostobrachial block as unique blocks or supplements to brachial plexus block; and,~~ (Core)

4.6.f.4.f. ~~technical and non-technical aspects unique to brachial plexus perineural catheter placement and management.~~ (Core)

4.6.f.5. ~~Fellows must demonstrate knowledge of regional anesthesia techniques, including lower extremity nerve block, to include:~~ (Core)

4.6.f.5.a. ~~anatomy and sonoanatomy of the lower extremity, including sciatic, femoral, lateral femoral cutaneous, and obturator nerves, as well as the adductor canal and lumbar plexus (psoas), and options for saphenous nerve blockade;~~ (Core)

4.6.f.5.b. ~~local anesthetics for lower extremity block, including agents, dose, duration of action, and adjuvants;~~ (Core)

4.6.f.5.c. ~~value and techniques of intravascular test dosing to minimize local anesthetic systemic toxicity associated with peripheral nerve block;~~ (Core)

4.6.f.5.d ~~differentiation between the various approaches to lower extremity blockade, including indications/contraindications, side effects, complications, and management specific to each; and,~~ (Core)

4.6.f.5.e ~~technical and non-technical aspects unique to lower extremity perineural catheter placement and management.~~ (Core)

4.6.f.6. ~~Fellows must demonstrate knowledge of regional anesthesia techniques, including truncal block, to include:~~ (Core)

4.6.f.6.a. ~~anatomy for intercostal, paravertebral, ilioinguinal-hypogastric, rectus sheath, and transversus abdominis plane blocks;~~ (Core)

4.6.f.6.b. ~~local anesthetics for truncal blockade: agents, dose, and duration of action;~~ (Core)

4.6.f.6.c. ~~indications, contraindications, side effects, complications, safety, and management of truncal blockade; and,~~ (Core)

~~4.6.f.6.d. technical and non-technical aspects unique to continuous truncal catheter placement and management.~~ ~~(Core)~~

~~4.6.f.7. Fellows must demonstrate knowledge of regional anesthesia techniques, including intravenous regional anesthesia, to include:~~ ~~(Core)~~

~~4.6.f.7.a. mechanism of action, indications, contraindications, advantages and disadvantages, adverse effects, complications, and management of intravenous regional anesthesia (IVRA); and,~~ ~~(Core)~~

~~4.6.f.7.b. agents used for IVRA, including local anesthetic choice, dosage, and use of adjuvants.~~ ~~(Core)~~

~~4.6.f.8. Fellows must demonstrate knowledge of regional anesthesia techniques, including complications of regional anesthesia and acute pain medicine, to include diagnosis and management of:~~ ~~(Core)~~

~~4.6.f.8.a. hemorrhagic complications, including complications due to anticoagulant and thrombolytic medications with specific reference to published guidelines;~~ ~~(Core)~~

~~4.6.f.8.b. infectious complications;~~ ~~(Core)~~

~~4.6.f.8.c. neurological complications;~~ ~~(Core)~~

~~4.6.f.8.c.1. This knowledge must include the interpretation of tests recommended following plexus/nerve injury, including electromyography, nerve conduction studies, somatosensory evoked potentials, and motor evoked potentials.~~ ~~(Core)~~

~~4.6.f.8.d. complications due to medicines, to include local anesthetic systemic toxicity and opioid-induced respiratory depression; and,~~ ~~(Core)~~

~~4.6.f.8.e. other complications, to include pneumothorax.~~ ~~(Core)~~

1. Describe the Review Committee's rationale for this revision:
   The Review Committee determined that many of the existing requirements in this section are overly prescriptive and do not meaningfully influence accreditation decisions, as citations are rarely issued based on these specific elements. The Committee concluded that programs can meet educational goals through a variety of effective instructional methods and that prescribing detailed approaches limits program flexibility without improving the quality of education and training. To better support innovation and reduce unnecessary regulatory burden, the Committee is proposing removal of these granular requirements. Additional explanatory detail will be incorporated into the Specialty-Specific Background and Intent to provide programs with context and guidance regarding the expected scope of educational content, while avoiding prescriptive directives in the requirements themselves.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   n/a

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   n/a

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **4.11.b.1.f.**

Requirement Revision (significant change only):
4.11.b.1.f. [Fellow education must include a minimum of five months of regional anesthesia experience, including: (Core)] a minimum of ~~50~~ 30 continuous peripheral nerve block catheter placement procedures, to include upper and lower extremity and truncal sites. (Core)

1. Describe the Review Committee's rationale for this revision:
   The Review Committee is proposing this reduction based on stakeholder feedback received during the public comment period and on evolving clinical practice patterns. Commenters noted that some continuous catheter techniques are used less frequently in contemporary practice due to the increased utilization of long-acting local anesthetic options, such as liposomal bupivacaine (EXPAREL). As these techniques expand, opportunities for fellows to perform traditional continuous catheter placements may be more limited at some institutions. The Committee concluded that a requirement of 50 procedures may no longer be realistic or necessary to achieve competence in continuous catheter techniques across a variety of clinical settings. Reducing the minimum to 30 maintains an appropriate threshold for exposure while allowing flexibility for programs to train fellows in a broader range of acute pain management modalities.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   The revised number continues to ensure adequate procedural experience for fellows to achieve competence while avoiding inflated procedural requirements that may pressure programs into prioritizing procedural quantity over high-quality, supervised learning. Aligning the requirement with current practice trends supports responsible education and training, appropriate supervision, and safe patient care.

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   n/a

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **NEW 4.11.b.4.**

Requirement Revision (significant change only):

4.11.b.4. Fellow education must include at least two weeks of addiction medicine. (Core)

1. Describe the Review Committee's rationale for this revision:
   The Review Committee added this requirement to ensure that fellows receive structured education in addiction medicine, recognizing its increasing relevance in the care of patients with acute and chronic pain. Fellows routinely treat patients with opioid tolerance, opioid use disorder, or complex pain–substance use interactions. Public comments and stakeholder feedback consistently emphasized the need for more explicit training in this area to support evidence-based care and safe opioid stewardship. The Committee determined that a defined educational experience of at least two weeks is necessary to standardize exposure across programs and to ensure fellows develop the foundational knowledge and skills required to manage these patient populations within a multidisciplinary framework.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   A dedicated addiction medicine experience enhances fellow education by providing structured opportunities to learn diagnostic principles, treatment strategies, and communication techniques for managing substance use disorders in the context of perioperative and acute pain care. This training supports safer prescribing practices, strengthens multimodal analgesic planning, and improves the quality of care provided to patients with coexisting pain and addiction.

3. How will the proposed requirement or revision impact continuity of patient care?
   No adverse impact is anticipated. Programs can incorporate the required experience into existing rotation structures while maintaining safe and continuous patient care coverage.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Most Sponsoring Institutions already have addiction medicine services or established clinical pathways for managing substance use disorders. Programs without a formal rotation may need to develop a relationship with an addiction medicine service, but significant new resources are not expected.

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **4.11.c.1.d.1.**

Requirement Revision (significant change only):

4.11.c.1.d.1. Fellows should attend a minimum of 10 local, regional, or national ~~multidisciplinary~~ conferences that are relevant to regional anesthesia and acute pain medicine, especially in orthopaedic surgery and pain medicine. (Detail)

1. Describe the Review Committee's rationale for this revision:

The Review Committee's intent for this requirement is for didactic content and engagement with didactics within the anesthesiology department, and the Sponsoring Institution may not offer that number of multidisciplinary conferences. The focus of this requirement is not specifically related to multidisciplinary conferences (for example, conferences with orthopaedic surgeons or allied health).

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   n/a

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   n/a

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **4.11.d.-4.11.d.20.**

Requirement Revision (significant change only):

4.11.d. The curriculum must be designed in order for fellows to develop skills and habits to:

~~4.11.d.1. identify strengths, deficiencies, and limits in knowledge and expertise. (Core)~~
~~4.11.d.2. set learning and practice improvement goals. (Core)~~
~~4.11.d.3. identify and perform appropriate learning activities, including didactic lectures and hands-on demonstrations that promulgate safety. (Core)~~
~~4.11.d.4. incorporate formative evaluation feedback into daily practice. (Core)~~
~~4.11.d.5. evaluate and apply evidence from scientific studies, expert guidelines, and practice pathways to patients' medical conditions. (Core)~~
~~4.11.d.6. apply information technology to obtain and record patient information, access institutional and national policies and guidelines, and participate in self education. (Core)~~
~~4.11.d.7. analyze their own practice with respect to patient outcomes (especially success and complications from regional blockade) and compare to available literature. (Core)~~
~~4.11.d.8. participate in the education of patients, families, students, fellows, and other health care professionals. (Core)~~
~~4.11.d.9. advocate for acute pain management and create best practices for pain management regarding major surgical procedures. (Core)~~
~~4.11.d.10. summarize information to the patient and family with respect to the options, alternatives, risks, and benefits of regional anesthesia and/or acute analgesic techniques in a manner that is clear, understandable, and ethical. (Core)~~

~~4.11.d.11. develop effective listening skills and answer questions appropriately in the process of obtaining informed consent. (Core)~~

~~4.11.d.12. operate effectively in a team environment, communicating and cooperating with surgeons, other physicians, nurses, pharmacists, physical therapists, and other members of the peri-operative team, including: (Core)~~

~~4.11.d.12.a. recognizing the roles of all team members; (Core)~~

~~4.11.d.12.b. communicating clearly in a professional manner that facilitates the achievement of care goals; (Core)~~

~~4.11.d.12.c. helping other members of the team to enhance the sharing of important information; and, (Core)~~

~~4.11.d.12.d. formulating care plans that utilize multidisciplinary team skills, such as a plan for facilitated recovery. (Core)~~

~~4.11.d.13. demonstrate integrity, honesty, and accountability in conducting the practice of medicine. (Core)~~

~~4.11.d.14. demonstrate a commitment to lifelong learning and excellence in practice. (Core)~~

~~4.11.d.15. demonstrate consistent subjugation of self-interest to the good of the patient and the health care needs of society. (Core)~~

~~4.11.d.16. demonstrate commitment to ethical principles in providing care, obtaining informed consent, and maintaining patient confidentiality. (Core)~~

~~4.11.d.17. effectively choose regional anesthesia techniques and approaches to promote peri-operative efficiency and improve patient outcomes. (Core)~~

~~4.11.d.18. understand the interaction of the regional anesthesia and acute pain medicine service with other elements of the health care system, including primary surgical and medical teams, and other consultant, nursing, pharmacy, and physical therapy services. (Core)~~

~~4.11.d.19. demonstrate awareness of health care costs and resource allocation, and the impact of their choices on those costs and resources, as well as strategies to accommodate hospital formulary, drug shortages, and cost control. (Core)~~

~~4.11.d.20. advocate for patients and their families within the health care system, and assist them in understanding and negotiating complexities in the system. (Core)~~

1. Describe the Review Committee's rationale for this revision:
   These program requirements are proposed to be removed, as they were previously under the former Common Program Requirement subcompetencies for interpersonal communication skills, systems-based practice, and practice-based learning and improvement. They should not be included in the fellowship Program Requirements because fellows would have demonstrated these competencies during residency. While it is expected that they will demonstrate those competencies during fellowship, excluding them from the Program Requirements is intended to allow programs to focus fellowship time on developing subspecialty-specific competencies.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   n/a

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   n/a

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **4.11.d.24.**

Requirement Revision (significant change only):

4.11.d.24**.** The curriculum must be designed in order for fellows to develop skills and habits to provide leadership in the organization and management of an acute pain medicine service within the hospital setting, comprising a variety of specialists to provide a comprehensive, multimodal acute pain management treatment plan and communication with the patient related to expectations and discharge instructions; and, (Core)

1. Describe the Review Committee's rationale for this revision:
   The Review Committee added this language to emphasize that leadership of an acute pain medicine service includes not only clinical and organizational management responsibilities, but also direct communication with patients regarding their pain management plans. The Committee recognized that patient comprehension of expectations and discharge instructions is integral to safe and effective acute pain care, and that fellows must be deliberately trained and assessed in this competency. The revision clarifies an existing expectation rather than introducing a new domain of practice, ensuring greater consistency across programs.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   This revision enhances fellow education by requiring explicit attention to patient communication as part of comprehensive acute pain service leadership. Clear explanation of expectations and discharge instructions improves patient understanding of multimodal pain plans, supports adherence to recommended therapies, and reduces the risk of unmanaged pain, medication misuse, or complications after discharge. Incorporating this communication component into the curriculum strengthens both patient safety and quality of care.

3. How will the proposed requirement or revision impact continuity of patient care?
   Clear discharge communication is a known factor in successful care transitions. By ensuring fellows develop competence in this area, the revision supports improved continuity across inpatient teams, outpatient providers, and the patient's self-management.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

n/a

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **4.13.c.**

Requirement Revision (significant change only):

~~4.13.c. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)~~

1. Describe the Review Committee's rationale for this revision:
   The Review Committee believes that the spirit of this requirement is covered under faculty responsibilities in Common Program Requirement 2.7.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   n/a

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   n/a

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **4.15.g**

Requirement Revision (significant change only):

~~4.15.g. Fellows must participate and direct cadaver anatomy laboratories for regional anesthesia if available. (Core)~~

1. Describe the Review Committee's rationale for this revision:
   The Committee determined that mandating participation and direction of cadaver anatomy laboratories is no longer necessary as a core requirement. Not all institutions have access to cadaver labs, and equivalent educational outcomes can be achieved through a variety of other modalities, including simulation-based training, ultrasound-guided anatomy teaching, and faculty-supervised procedural instruction. Retaining this requirement created inconsistency across programs and placed undue emphasis on a resource that is not universally available. Its deletion supports equity among programs while allowing flexibility in choosing educational approaches that meet competency goals.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

n/a. This is a deletion of a prescriptive modality rather than a substantive educational or safety standard. Programs will retain responsibility for ensuring fellows develop anatomical and procedural competence through appropriate alternative means.

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   The deletion reduces, rather than increases, resource expectations, since programs are no longer required to secure access to or administer cadaver laboratory experiences.

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **4.15.h.**

Requirement Revision (significant change only):

~~4.15.h. Fellows must develop teaching techniques by instructing residents and/or medical students at the bedside with the supervision of faculty member(s).~~ ~~(Core)~~

1. Describe the Review Committee's rationale for this revision:
   The Committee found that while developing teaching skills remains important, mandating a specific teaching setting (bedside instruction) is unnecessarily restrictive. Programs can foster educational skill development through multiple modalities, including simulation, case-based teaching, and structured debriefing, without requiring bedside instruction opportunities that may not be consistently available in all training environments. Removing the requirement enhances flexibility and reduces unnecessary accreditation burden while preserving the broader expectation that fellows engage in professional development.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   n/a

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   n/a

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **4.15.i.**

Requirement Revision (significant change only):

~~4.15.i. Fellows must review and enhance web-based teaching resources, such as resident teaching materials, curriculum documents, and self-study and testing materials.~~ ~~(Core)~~

1. Describe the Review Committee's rationale for this revision:
   The Committee concluded that requiring fellows to review and enhance web-based teaching resources places an administrative burden on learners and assumes institutional infrastructure that may not be present in all settings. While participation in educational activities can be valuable, mandating involvement in maintaining or developing program-level educational content is beyond the intended scope of fellow competence development. The deletion removes an expectation that does not directly align with the core clinical and leadership competencies emphasized in the fellowship.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   n/a

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   n/a

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **NEW 4.15.f.**

Requirement Revision (significant change only):

4.15.f. Each fellow must receive a minimum of 12 non-clinical days per year to facilitate fellow involvement in scholarly activities. (Core)

1. Describe the Review Committee's rationale for this revision:
   This requirement originated from feedback received during the public comment period prior to the Committee's initiation of the major revision process. Commenters indicated that existing clinical demands often limit fellows' ability to meaningfully engage in scholarly activity, despite scholarship being a core expectation of subspecialty education and training. The Committee agreed that dedicated, protected time is essential to ensure equitable scholarly opportunities across programs and to support fellows' development as academic physicians who can contribute to research, quality improvement, and the advancement of the subspecialty. Establishing a defined minimum standard provides clarity, promotes consistency in education and training experiences, and aligns regional anesthesiology and acute pain medicine fellowship expectations with practices in other subspecialties where protected scholarly time is routinely supported.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   Allocating dedicated non-clinical time supports fellows' ability to engage in rigorous scholarly activity, including research, quality improvement projects, and educational scholarship. These activities contribute to the continual evaluation and improvement of pain management practices, which can ultimately enhance patient safety and care quality. Structured scholarly involvement also advances fellows' analytical and leadership skills, supporting long-term professional growth.

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Some programs may need to adjust scheduling models to ensure fellows receive the required non-clinical days, but significant new resources are not anticipated. Institutions already support scholarly activity expectations, and the defined minimum helps formalize existing educational practices rather than introduce new infrastructure or staffing needs.

5. How will the proposed revision impact other accredited programs?
   n/a

Requirement #: **5.1.h.**

Requirement Revision (significant change only):

~~5.1.h. Assessments should include evaluations of interpersonal communication and relationship skills, fund of knowledge, manual skills, decision-making skills, and critical analysis of clinical situations.~~ ~~(Detail)~~

1. Describe the Review Committee's rationale for this revision:
   This requirement was deleted because it is covered under Common Program Requirement 5.1.b.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   n/a

3. How will the proposed requirement or revision impact continuity of patient care?
   n/a

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   n/a

5. How will the proposed revision impact other accredited programs?
   n/a