



**Accreditation Council for
Graduate Medical Education**

**ACGME Program Requirements for
Graduate Medical Education
in Combined Internal Medicine - Pediatrics**

ACGME approved major revision: September 24, 2017; effective: July 1, 2018

ACGME Program Requirements for Graduate Medical Education in Internal Medicine-Pediatrics

Common Program Requirements are in **BOLD**

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Introduction

Int.A. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

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

Int.B. Residency education in internal medicine-pediatrics encompasses integrative training in internal medicine and pediatrics. The combined training allows development of a physician knowledgeable in the full spectrum of human development, from newborns to the aged. It includes the study and practice of health promotion, disease prevention, diagnosis, care, and treatment of infants, children, adolescents, men, and women. The scientific model of problem solving and evidence-based decision making with a commitment to lifelong learning and an attitude of caring derived from humanistic and professional values is integral to the specialty. The combined internal medicine-pediatrics program prepares graduates to provide health care in a broad spectrum of practice that includes primary and subspecialty care and ambulatory and hospital based care, with additional subspecialty training in urban, rural, and global settings.

Int.C. Duration of Education

The educational program in internal medicine-pediatrics must be 48 months in length. ^{(Core)*}

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites. (Core)

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program. (Core)

I.A.1. Relation to Core Residencies

I.A.1.a) The four-year combined training in internal medicine and pediatrics must be provided by ACGME-accredited categorical programs in these specialties that are sponsored by the same ACGME-accredited Sponsoring Institution and are in close geographic proximity. (Core)

I.A.1.a).(1) The one exception is when the pediatrics program is sponsored by a children's hospital, in which case the designated institutional official (DIO) of the institution that sponsors the internal medicine residency program may have responsibility for oversight of the combined program. (Core)

I.A.1.b) The categorical programs must each participate in only one internal medicine-pediatrics program. (Core)

I.A.1.c) The residents in the core and combined programs must interact at all levels of training. (Core)

I.A.2. Program Director Support

I.A.2.a) The program director should receive support amounting to at least 50 percent of the program director's salary. (Detail)

I.A.2.a).(1) The program director must not be required to generate clinical or other income to provide this administrative support. (Core)

I.B. Participating Sites

I.B.1. **There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.** (Core)

The PLA should:

I.B.1.a) **identify the faculty who will assume both educational and**

supervisory responsibilities for residents; ^(Detail)

- I.B.1.b) **specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;** ^(Detail)
- I.B.1.c) **specify the duration and content of the educational experience; and,** ^(Detail)
- I.B.1.d) **state the policies and procedures that will govern resident education during the assignment.** ^(Detail)
- I.B.2. **The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).** ^(Core)

II. Program Personnel and Resources

II.A. Program Director

- II.A.1. **There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director.** ^(Core)
- II.A.1.a) **The program director must submit this change to the ACGME via the ADS.** ^(Core)
- II.A.2. **The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.** ^(Detail)
- II.A.3. **Qualifications of the program director must include:**
- II.A.3.a) **requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;** ^(Core)
- II.A.3.b) **current certification in the specialty by the American Board of Internal Medicine (ABIM) and the American Board of Pediatrics (ABP) or specialty qualifications that are acceptable to the Review Committee;** ^(Core)
- II.A.3.b).(1) **Current certification in the specialty by the American Osteopathic Board of Internal Medicine (AOBIM) and the American Osteopathic Board of Pediatrics (AOBP) are acceptable to the Review Committee.** ^(Core)
- II.A.3.c) **current medical licensure and appropriate medical staff appointment; and,** ^(Core)

II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. ^(Core)

The program director must:

- II.A.4.a)** oversee and ensure the quality of didactic and clinical education in all sites that participate in the program; ^(Core)
- II.A.4.b)** approve a local director at each participating site who is accountable for resident education; ^(Core)
- II.A.4.c)** approve the selection of program faculty as appropriate; ^(Core)
- II.A.4.d)** evaluate program faculty; ^(Core)
- II.A.4.e)** approve the continued participation of program faculty based on evaluation; ^(Core)
- II.A.4.f)** monitor resident supervision at all participating sites; ^(Core)
- II.A.4.g)** prepare and submit all information required and requested by the ACGME; ^(Core)
- II.A.4.g).(1)** This includes but is not limited to the program application forms and annual program updates to the ADS, and ensure that the information submitted is accurate and complete. ^(Core)
- II.A.4.h)** ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution; ^(Detail)
- II.A.4.i)** provide verification of residency education for all residents, including those who leave the program prior to completion; ^(Detail)
- II.A.4.j)** implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, ^(Core)

and, to that end, must:
 - II.A.4.j).(1)** distribute these policies and procedures to the residents and faculty; ^(Detail)
 - II.A.4.j).(2)** monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements; ^(Core)

- II.A.4.j).(3) **adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and, (Detail)**
- II.A.4.j).(4) **if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue. (Detail)**
- II.A.4.k) **monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged; (Detail)**
- II.A.4.l) **comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents; (Detail)**
- II.A.4.m) **be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures; (Detail)**
- II.A.4.n) **obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including: (Core)**
 - II.A.4.n).(1) **all applications for ACGME accreditation of new programs; (Detail)**
 - II.A.4.n).(2) **changes in resident complement; (Detail)**
 - II.A.4.n).(3) **major changes in program structure or length of training; (Detail)**
 - II.A.4.n).(4) **progress reports requested by the Review Committee; (Detail)**
 - II.A.4.n).(5) **requests for increases or any change to resident duty hours; (Detail)**
 - II.A.4.n).(6) **voluntary withdrawals of ACGME-accredited programs; (Detail)**
 - II.A.4.n).(7) **requests for appeal of an adverse action; and, (Detail)**
 - II.A.4.n).(8) **appeal presentations to a Board of Appeal or the ACGME. (Detail)**
- II.A.4.o) **obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses: (Detail)**
 - II.A.4.o).(1) **program citations, and/or, (Detail)**

II.A.4.o).(2) request for changes in the program that would have significant impact, including financial, on the program or institution. ^(Detail)

II.A.5. The program director should oversee an effective program for advising residents. ^(Detail)

II.A.6. The program directors of the related categorical programs and the program director(s) of the combined program must demonstrate collaboration and coordination of curriculum and rotations. ^(Core)

II.A.6.a) To achieve appropriate coordination of the combined program and shared accountability, including integration of training and supervision in each discipline, the program directors of the categorical programs and the program director(s) of the combined program should hold at least quarterly meetings that involve consultation with faculty from both departments, as well as internal medicine-pediatrics residents and/or residents from both departments. ^(Detail)

II.A.7. Associate Program Directors

Associate program directors (APDs) are faculty members who assist the program director in the administrative and clinical oversight of the educational program.

II.A.7.a) Qualifications of APDs must include current certification in internal medicine or its subspecialties by the ABIM or AOBIM and/or current certification in general pediatrics or its subspecialties by the ABP or AOBP. ^(Core)

II.A.7.b) The minimum amount of full-time equivalent (FTE) support provided for APDs must be based on the size of the program as follows : ^(Detail)

Number of Residents	APD FTE
16-30	.25
≥31	.5

II.B. Faculty

II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location. ^(Core)

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents; ^(Core)

- II.B.1.b)** administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas; and, ^(Core)
- II.B.1.c) meet professional standards of behavior. ^(Core)
- II.B.2.** **The physician faculty must have current certification in the specialty by the American Board of Internal Medicine or the American Board of Pediatrics or possess qualifications judged acceptable to the Review Committee.** ^(Core)
- II.B.2.a) Current certification in the specialty by the AOBIM or the AOBP is acceptable to the Review Committee. ^(Core)
- II.B.3.** **The physician faculty must possess current medical licensure and appropriate medical staff appointment.** ^(Core)
- II.B.4.** **The non-physician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.** ^(Core)
- II.B.5.** **The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.** ^(Core)
- II.B.5.a)** **The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.** ^(Detail)
- II.B.5.b)** **Some members of the faculty should also demonstrate scholarship by one or more of the following:**
- II.B.5.b).(1)** **peer-reviewed funding;** ^(Detail)
- II.B.5.b).(2)** **publication of original research or review articles in peer reviewed journals, or chapters in textbooks;** ^(Detail)
- II.B.5.b).(3)** **publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,** ^(Detail)
- II.B.5.b).(4)** **participation in national committees or educational organizations.** ^(Detail)
- II.B.5.c)** **Faculty should encourage and support residents in scholarly activities.** ^(Core)
- II.B.6. Core Faculty
- There must be institutionally-based core faculty members in addition to the program director and associate program directors. The core faculty members must work closely with the program director and APDs, assist in developing and implementing the evaluation system, and teach and advise residents. ^(Core)

Core faculty:

- II.B.6.a) must be ABIM- or AOBIM-certified internists and/or ABP- or AOBP-certified pediatricians who are clinically active, either in direct patient care or in the supervision of patient care; ^(Core)
- II.B.6.b) must dedicate an average of at least 15 hours per individual per week throughout the year to residency training; ^(Core)
- II.B.6.c) should be specifically trained in the evaluation and assessment of the ACGME competencies; ^(Detail)
- II.B.6.d) should spend significant time in the evaluation of residents, including the direct observation of residents with patients; and, ^(Detail)
- II.B.6.e) should advise residents with respect to their career and educational goals. ^(Detail)

II.B.7. Pediatric Subspecialty Faculty

There must be faculty members with pediatric subspecialty board certification who function on an ongoing basis as integral parts of the clinical and instructional components of the program in both inpatient and outpatient settings. ^(Core)

II.B.8. Faculty Development

- II.B.8.a) Program leadership and core faculty members must participate in faculty or leadership development programs relevant to their roles in the program. ^(Core)
- II.B.8.a).(1) Such participation should occur at least annually. ^(Detail)
- II.B.8.b) All faculty members involved in the education of residents must participate in programs to enhance the effectiveness of their skills as educators, based on their roles in the program. ^(Core)
- II.B.8.c) The program director and APD(s) should participate in academic societies and in educational programs designed to enhance their educational and administrative skills. ^(Detail)

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program. ^(Core)

- II.C.1. The program must provide support for a program coordinator(s) and other support personnel required for operation of the program. ^(Core)

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements. ^(Core)

- II.D.1. The Sponsoring Institution must provide the broad range of facilities and clinical support services required to provide comprehensive care of the full spectrum of adult and pediatric patients. ^(Core)
- II.D.2. Additional services should include those for cardiac catheterization, bronchoscopy, gastrointestinal endoscopy, non-invasive cardiology studies, pulmonary function studies, hemodialysis, and imaging studies, including radionuclide, ultrasound, fluoroscopy, angiography, computerized tomography, and magnetic resonance imaging. ^(Detail)
- II.D.3. Adequate clinical and teaching space must be available, including meeting rooms, classrooms, examination rooms, computers, visual and other educational aids, medical and electronic resources to achieve all of the required educational outcomes, and office space for teaching staff. ^(Core)
- II.D.4. In addition to an emergency facility providing care for adults, there must be an emergency facility that specializes in the care of pediatric patients and that receives pediatric patients who have been transported via the Emergency Medical Services system. ^(Core)
- II.D.5. The program must provide a volume, variety, and complexity in diagnoses and age, from infants to geriatric patients, sufficient for residents to achieve all of the required educational outcomes. ^(Core)
- II.D.6. There should be services available from other health care professionals such as nurses, social workers, case managers, language interpreters, and dietitians. ^(Detail)
- II.D.7. Consultations from other clinical services should be available in a timely manner in all care settings where the residents work. All consultations should be performed by or under the supervision of a qualified specialist. ^(Detail)
- II.D.8. The program should provide residents with access to training using simulation. ^(Detail)
- II.D.9. The program must provide access to an electronic health record. In the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development, and progress towards its implementation. ^(Core)

II.E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic

medical literature databases with search capabilities should be available.
(Detail)

III. Resident Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements. (Core)

III.A.1. Eligibility Requirements – Residency Programs

III.A.1.a) All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, or in Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada. Residency programs must receive verification of each applicant's level of competency in the required clinical field using ACGME or CanMEDS Milestones assessments from the prior training program. (Core)

III.A.1.b) A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. (Core)

III.A.1.c) A Review Committee may grant the exception to the eligibility requirements specified in Section III.A.2.b) for residency programs that require completion of a prerequisite residency program prior to admission. (Core)

III.A.1.d) Review Committees will grant no other exceptions to these eligibility requirements for residency education. (Core)

III.A.1.e) Residents must not enter the combined residency program beyond the beginning of the PGY-2 level. (Core)

III.A.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, or in an RCPSC-accredited or CFPC- accredited residency program located in Canada. (Core)

III.A.2.a) Fellowship programs must receive verification of each entering fellow's level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program. ^(Core)

III.A.2.b) Fellow Eligibility Exception

A Review Committee may grant the following exception to the fellowship eligibility requirements:

An ACGME-accredited fellowship program may accept an exceptionally qualified applicant**, who does not satisfy the eligibility requirements listed in Sections III.A.2. and III.A.2.a), but who does meet all of the following additional qualifications and conditions: ^(Core)

III.A.2.b).(1) Assessment 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.2.b).(2) Review and approval of the applicant's exceptional qualifications by the GMEC or a subcommittee of the GMEC; and ^(Core)

III.A.2.b).(3) Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and; ^(Core)

III.A.2.b).(4) For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and, ^(Core)

III.A.2.b).(5) Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant's Milestones evaluation conducted at the conclusion of the residency program. ^(Core)

III.A.2.b).(5).(a) If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not

count toward time in fellowship training. ^(Core)

**** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.**

III.B. Number of Residents

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

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

III.C. Resident Transfers

III.C.1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident. ^(Detail)

III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents who may leave the program prior to completion. ^(Detail)

III.D. Appointment of Fellows and Other Learners

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

III.D.1. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines. ^(Detail)

IV. Educational Program

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

IV.A.1. Overall educational goals for the program, which the program must make available to residents and faculty; ^(Core)

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty at least annually, in either written or electronic form; ^(Core)

IV.A.3. Regularly scheduled didactic sessions; ^(Core)

IV.A.3.a) The core curriculum must include a didactic program based upon the core knowledge content of internal medicine and pediatrics to ensure each resident acquires the knowledge, skills, and attitudes needed for the practice of medicine and pediatrics. ^(Core)

IV.A.3.a).(1) The program must afford each resident an opportunity to review all of the core curriculum topics. ^(Core)

IV.A.3.a).(1).(a) The didactic program should include lectures, web-based content, pod casts, etc. ^(Detail)

IV.A.3.a).(2) Residents should have the opportunity to participate in morning report, grand rounds, journal club, and morbidity and mortality (or quality improvement) conferences that also involve faculty. ^(Detail)

IV.A.3.a).(3) The program should document monthly meetings for educational activities with internal medicine-pediatrics residents, such as jointly-sponsored journal clubs, clinic conferences, occasional combined grand rounds, conferences on medical ethics program administration and research. ^(Detail)

IV.A.3.a).(4) The program should provide opportunities for residents to have peer-peer and peer-faculty interaction. ^(Detail)

IV.A.3.b) Patient-based teaching must include direct interaction between the resident and the attending physician at the patient's bedside, in consultative services or in clinic settings with discussion of pathophysiology and use of up-to-date diagnostic and therapeutic evidence. ^(Core)

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and, ^(Core)

IV.A.4.a) Patient care discussions between residents and qualified generalist or subspecialist faculty members must occur as part of resident assignments. ^(Core)

IV.A.5. ACGME Competencies

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

IV.A.5.a)

Patient Care and Procedural Skills

IV.A.5.a).(1)

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents: ^(Outcome)

must demonstrate the ability to:

IV.A.5.a).(1).(a)

manage patients in a variety of roles within a health system with progressive responsibility, to include serving as the direct provider, the leader or member of a multi-disciplinary team of providers, a consultant to other physicians, and a teacher to the patient, family, and other physicians; ^(Outcome)

IV.A.5.a).(1).(b)

manage patients in the prevention, counseling, detection, and diagnosis and treatment of gender-specific diseases; ^(Outcome)

IV.A.5.a).(1).(c)

manage patients in a variety of health care settings, to include the inpatient ward, the critical care units, the emergency setting, and the ambulatory setting; ^(Outcome)

IV.A.5.a).(1).(d)

manage patients across the spectrum of clinical disorders seen in the practice of general internal medicine and pediatrics in both inpatient and ambulatory settings; ^(Outcome)

IV.A.5.a).(1).(e)

manage a sufficient number of undifferentiated acutely and severely ill patients; ^(Outcome)

IV.A.5.a).(1).(f)

gather essential and accurate information about the patient; ^(Outcome)

IV.A.5.a).(1).(g)

organize and prioritize responsibilities to provide patient care that is safe, effective, and efficient; ^(Outcome)

IV.A.5.a).(1).(h)

provide transfer of care that ensures seamless transitions; ^(Outcome)

IV.A.5.a).(1).(i)

interview patients and families about the particulars of the medical condition for which they seek care, with specific attention to behavioral, psychosocial, environmental, and family unit correlates of disease; ^(Outcome)

IV.A.5.a).(1).(j)

perform complete and accurate physical examinations; ^(Outcome)

IV.A.5.a).(1).(k)	make informed diagnostic and therapeutic decisions that result in optimal clinical judgment; (Outcome)
IV.A.5.a).(1).(l)	develop and carry-out management plans; (Outcome)
IV.A.5.a).(1).(m)	provide effective health maintenance and anticipatory guidance; (Outcome)
IV.A.5.a).(1).(n)	provide appropriate role modeling; and, (Outcome)
IV.A.5.a).(1).(o)	provide appropriate supervision. (Outcome)
IV.A.5.a).(2)	Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Residents: (Outcome)
IV.A.5.a).(2).(a)	must demonstrate the ability to manage patients using the laboratory and imaging techniques appropriately; (Outcome)
IV.A.5.a).(2).(b)	must treat their patient's conditions with practices that are safe, scientifically based, effective, efficient, timely, and cost effective; (Outcome)
IV.A.5.a).(2).(c)	must be able to competently perform procedures used by an internist and pediatrician in general practice, including being able to describe the steps in the procedure, indications, contraindications, complications, pain management, post-procedure care, and interpretation of applicable results; (Outcome)
IV.A.5.a).(2).(d)	must demonstrate procedural competence by performing the following procedures on pediatric patients; and, (Outcome)
IV.A.5.a).(2).(d).(i)	bag-mask ventilation; (Outcome)
IV.A.5.a).(2).(d).(ii)	bladder catheterization; (Outcome)
IV.A.5.a).(2).(d).(iii)	immunizations; (Outcome)
IV.A.5.a).(2).(d).(iv)	incision and drainage of abscess; (Outcome)
IV.A.5.a).(2).(d).(v)	lumbar puncture; (Outcome)
IV.A.5.a).(2).(d).(vi)	neonatal endotracheal intubation; (Outcome)
IV.A.5.a).(2).(d).(vii)	peripheral intravenous catheter placement; (Outcome)

- IV.A.5.a).(2).(d).(viii) reduction of simple dislocation; (Outcome)
- IV.A.5.a).(2).(d).(ix) simple laceration repair; (Outcome)
- IV.A.5.a).(2).(d).(x) simple removal of foreign body; (Outcome)
- IV.A.5.a).(2).(d).(xi) temporary splinting of fracture; (Outcome)
- IV.A.5.a).(2).(d).(xii) umbilical catheter placement; and, (Outcome)
- IV.A.5.a).(2).(d).(xiii) venipuncture. (Outcome)
- IV.A.5.a).(2).(e) must complete training and maintain certification in Pediatric Advanced Life Support, including simulated placement of an intraosseous line, and neonatal resuscitation. (Outcome)

IV.A.5.b)

Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents: (Outcome)

- IV.A.5.b).(1) must demonstrate knowledge of those areas appropriate for an internal medicine and pediatrics specialist, specifically: (Outcome)
- IV.A.5.b).(1).(a) the broad spectrum of clinical disorders seen in the practices of general internal medicine and pediatrics; and, (Outcome)
- IV.A.5.b).(1).(b) the core content of general internal medicine and pediatrics, including the subspecialties and relevant specialties outside of internal medicine and pediatrics. (Outcome)
- IV.A.5.b).(2) must demonstrate sufficient knowledge:
- IV.A.5.b).(2).(a) to evaluate patients with an undiagnosed and undifferentiated presentation; (Outcome)
- IV.A.5.b).(2).(b) to treat medical conditions common to children and adults; (Outcome)
- IV.A.5.b).(2).(c) to provide preventive care; (Outcome)
- IV.A.5.b).(2).(d) to interpret clinical tests and images commonly used by general internists and pediatricians; (Outcome)
- IV.A.5.b).(2).(e) to recognize and provide initial management of

- emergency medical problems; (Outcome)
- IV.A.5.b).(2).(f) of pharmacotherapy; and, (Outcome)
- IV.A.5.b).(2).(g) to appropriately use and perform diagnostic and therapeutic procedures. (Outcome)
- IV.A.5.b).(3) must demonstrate sufficient knowledge of the basic and clinically supportive sciences appropriate to internal medicine and pediatrics; (Outcome)
- IV.A.5.b).(4) must demonstrate an understanding of the indications and contraindications for, and complications of the following pediatric procedures; and, (Outcome)
- IV.A.5.b).(4).(a) arterial line placement; (Outcome)
- IV.A.5.b).(4).(b) arterial puncture; (Outcome)
- IV.A.5.b).(4).(c) chest tube placement; (Outcome)
- IV.A.5.b).(4).(d) circumcision; (Outcome)
- IV.A.5.b).(4).(e) endotracheal intubation of non-neonates; and, (Outcome)
- IV.A.5.b).(4).(f) thoracentesis. (Outcome)
- IV.A.5.b).(5) should receive real and/or simulated training when these procedures are important for a resident's post-residency career. (Detail)

IV.A.5.c)

Practice-based Learning and Improvement

Residents 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 life-long learning.
(Outcome)

Residents are expected to develop skills and habits to be able to meet the following goals:

- IV.A.5.c).(1) **identify strengths, deficiencies, and limits in one's knowledge and expertise;** (Outcome)
- IV.A.5.c).(2) **set learning and improvement goals;** (Outcome)
- IV.A.5.c).(3) **identify and perform appropriate learning activities;** (Outcome)
- IV.A.5.c).(4) **systematically analyze practice using quality**

- improvement methods, and implement changes with the goal of practice improvement;** (Outcome)
- IV.A.5.c).(5) incorporate formative evaluation feedback into daily practice;** (Outcome)
- IV.A.5.c).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;** (Outcome)
- IV.A.5.c).(7) use information technology to optimize learning;** (Outcome)
- IV.A.5.c).(8) participate in the education of patients, families, students, residents and other health professionals;** (Outcome)
- IV.A.5.c).(9) be an effective teacher; and,** (Outcome)
- IV.A.5.c).(10) take primary responsibility for lifelong learning to improve knowledge, skills, and practice performance through familiarity with general and experience-specific goals and objectives and attendance at conferences.** (Outcome)

IV.A.5.d) Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Outcome)

Residents are expected to:

- IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;** (Outcome)
- IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies;** (Outcome)
- IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group;** (Outcome)
- IV.A.5.d).(4) act in a consultative role to other physicians and health professionals;** (Outcome)
- IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable; and,** (Outcome)
- IV.A.5.d).(6) demonstrate the insight and understanding into emotion and human response to emotion that allows one to appropriately develop and manage human interactions.**

(Outcome)

IV.A.5.e)

Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Residents are expected to demonstrate:

- IV.A.5.e).(1)** **compassion, integrity, and respect for others;** (Outcome)
- IV.A.5.e).(2)** **responsiveness to patient needs that supersedes self-interest;** (Outcome)
- IV.A.5.e).(3)** **respect for patient privacy and autonomy;** (Outcome)
- IV.A.5.e).(4)** **accountability to patients, society and the profession;** (Outcome)
- IV.A.5.e).(5)** **sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation; and,** (Outcome)
- IV.A.5.e).(6)** a commitment to engage in personal and professional development that will sustain them in balancing their professional life with a healthy and productive personal life, including: (Outcome)
 - IV.A.5.e).(6).(a)** self-awareness of one's own knowledge, skills, and emotional limitations that leads to appropriate help-seeking behaviors; (Outcome)
 - IV.A.5.e).(6).(b)** healthy responses to stressors; (Outcome)
 - IV.A.5.e).(6).(c)** management of conflict between one's personal and professional responsibilities; (Outcome)
 - IV.A.5.e).(6).(d)** flexibility and maturity in adjusting to change with the capacity to alter one's own behaviors; (Outcome)
 - IV.A.5.e).(6).(e)** trustworthiness that makes colleagues feel secure when one is responsible for the care of patients; (Outcome)
 - IV.A.5.e).(6).(f)** leadership skills that enhance team function, the learning environment, and/or the health care delivery system/environment with the ultimate intent of improving care of patients; (Outcome)
 - IV.A.5.e).(6).(g)** self-confidence that puts patients, families, and

members of the health care team at ease; and,
(Outcome)

IV.A.5.e).(6).(h)

the capacity to accept that ambiguity is part of clinical medicine and to recognize the need for and to utilize appropriate resources in dealing with uncertainty. (Outcome)

IV.A.5.f)

Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.
(Outcome)

Residents are expected to:

IV.A.5.f).(1)

work effectively in various health care delivery settings and systems relevant to their clinical specialty; (Outcome)

IV.A.5.f).(2)

coordinate patient care within the health care system relevant to their clinical specialty; (Outcome)

IV.A.5.f).(3)

incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; (Outcome)

IV.A.5.f).(4)

advocate for quality patient care and optimal patient care systems; (Outcome)

IV.A.5.f).(5)

work in interprofessional teams to enhance patient safety and improve patient care quality; (Outcome)

IV.A.5.f).(6)

participate in identifying system errors and implementing potential systems solutions; (Outcome)

IV.A.5.f).(7)

work in teams and effectively transmit necessary clinical information to ensure safe and proper care of patients including the transition of care between settings; and,
(Outcome)

IV.A.5.f).(8)

advocate for the promotion of health and the prevention of disease and injury in populations. (Outcome)

IV.A.6.

Curriculum

IV.A.6.a)

The majority of educational experiences that constitute the combined internal medicine-pediatrics curriculum must be derived from the educational experiences and training that have been accredited as part of the categorical internal medicine program by

the Review Committee for Internal Medicine and as part of the categorical pediatrics program by the Review Committee for Pediatrics. ^(Core)

- IV.A.6.b) The curriculum must provide a cohesive planned educational experience, and not simply be a series of rotations between the two specialties. ^(Core)
- IV.A.6.c) For each required rotation (four-week or one-month block or longitudinal experience), a faculty member must be responsible for curriculum development, and ensuring orientation, supervision, teaching, and timely feedback and evaluation. ^(Core)
- IV.A.6.d) Residents must have graded responsibility for patient care and teaching. ^(Core)
- IV.A.6.e) There must be 24 months of training in each specialty. ^(Core)
- IV.A.6.e).(1) Twenty-two months of training must be in clinical rotations and other educational experiences. ^(Core)
- IV.A.6.f) Night assignments should have formal goals, objectives, and a specific evaluation component. ^(Core)
- IV.A.6.g) Off-site elective experiences should not exceed two months in either specialty (no more than two months in internal medicine, and no more than two months in pediatrics) during the four years of training. ^(Detail)
- IV.A.6.h) Continuous assignments to one specialty or the other should be for periods of at least one rotation and not more than six rotations. ^(Detail)
- IV.A.6.i) In order to provide a breadth of exposure, unnecessary duplication of educational experiences should be avoided. ^(Detail)
- IV.A.7. Continuity Clinics
 - IV.A.7.a) The longitudinal continuity experience must allow residents to develop a continuous, long-term therapeutic relationship with a panel of general medicine and pediatric patients; ^(Core)
 - IV.A.7.b) The continuity clinic experience must ensure a minimum of 36 half-day sessions per year of a longitudinal outpatient experience. ^(Core)
 - IV.A.7.b).(1) The sessions must be scheduled over a minimum of 26 weeks per year. ^(Core)
 - IV.A.7.b).(2) Continuity clinic experience should be obtained either by a combined internal medicine-pediatrics continuity clinic or by alternating internal medicine and pediatrics continuity

clinics. ^(Detail)

- IV.A.7.b).(3) Programs should develop models and schedules for ambulatory training that minimize conflicting inpatient and outpatient responsibilities. ^(Detail)
- IV.A.7.b).(4) Each resident's longitudinal continuity experience:
- IV.A.7.b).(4).(a) should include the resident serving as the primary physician in a medical home model for a panel of patients, with responsibility for chronic disease management, management of acute health problems, and preventive health care for their patients; ^(Detail)
- IV.A.7.b).(4).(b) should include evaluation of performance data for each resident's continuity panel of patients relating to both chronic disease management and preventive health care; ^(Detail)
- IV.A.7.b).(4).(c) should include faculty guidance for developing a data-based action plan that is evaluated at least twice a year; ^(Detail)
- IV.A.7.b).(4).(d) should include resident participation in coordination of care across health care settings; ^(Detail)
- IV.A.7.b).(4).(d).(i) Residents should be available to participate in the management of their continuity panel of patients between outpatient visits. ^(Detail)
- IV.A.7.b).(4).(d).(ii) There should be systems of care to provide coverage of urgent problems when a resident is not readily available. ^(Detail)
- IV.A.7.b).(4).(e) must include supervision by faculty who develop a longitudinal relationship with residents throughout the duration of their continuity experience; ^(Core)
- IV.A.7.b).(4).(f) should maintain a ratio of residents or other learners to faculty preceptors not to exceed 4:1; and, ^(Detail)
- IV.A.7.b).(4).(g) must have sufficient supervision and teaching. ^(Core)
- IV.A.7.b).(4).(g).(i) Faculty should not have other patient care duties while supervising more than two residents or other learners. ^(Detail)
- IV.A.7.b).(4).(g).(ii) Other faculty responsibilities should not detract from the supervision and teaching of residents. ^(Detail)

- IV.A.7.b).(4).(g).(iii) Faculty should have expertise in primary care and the principles of the medical home. (Detail)
- IV.A.7.b).(5) There must be an adequate volume of patients to ensure exposure to the spectrum of normal development at all age levels, as well as the longitudinal management of children and adults with special health care needs and chronic conditions. (Core)
- IV.A.7.b).(6) There must be an even distribution of pediatric and adult patients, whether the experience occurs in combined or alternating separate clinic settings. (Core)
- IV.A.7.b).(6).(a) Residents should see a minimum of 54 adult and a minimum of 54 pediatric patient visits in the PGY-1. (Detail)
- IV.A.7.b).(6).(b) Residents should see a minimum of 72 adult and a minimum of 72 pediatric patient visits in the PGY-2. (Detail)
- IV.A.7.b).(6).(c) Residents should see a minimum of 90 adult and a minimum of 90 pediatric patient visits in the PGY-3. (Detail)
- IV.A.7.b).(6).(d) Residents should see a minimum of 90 adult and a minimum of 90 pediatric patient visits in the PGY-4. (Detail)
- IV.A.7.b).(7) Programs must not be structured to provide sequential continuity experiences, (e.g., 24 months of internal medicine followed by 24 months of pediatrics). (Core)
- IV.A.7.b).(8) Residents should follow their continuity patients during the course of a hospitalization. (Detail)
- IV.A.7.b).(9) PGY-4 residents should continue this experience at the same clinical site or, if appropriate for an individual resident's career goals, sessions in the final year may take place in a longitudinal subspecialty clinic or alternate primary care site. (Detail)
- IV.A.8. Intensive Care
- IV.A.8.a) The total required critical care experience must not exceed eight months, and must include at least three months in pediatrics and at least two months in internal medicine. (Core)
- IV.A.9. Internal Medicine Component

The training in internal medicine for the combined program must include:

- IV.A.9.a) 20 months of direct patient care or supervision of more junior residents in direct patient care; ^(Core)
- IV.A.9.a).(1) This experience should include at least six months of supervision of the care provided by more junior residents. ^(Detail)
- IV.A.9.b) experience in the Emergency Department; ^(Core)
- IV.A.9.b).(1) This should include at least a one-month experience in the Emergency Department during the first or second year. ^(Detail)
- IV.A.9.c) clinical experiences with hospitalized patients; ^(Core)
- IV.A.9.c).(1) At least one-third of the residency training must occur in the ambulatory setting and at least one-third must occur in the inpatient setting. ^(Core)
- IV.A.9.c).(2) The inpatient experience should be at least eight months in duration. ^(Detail)
- IV.A.9.c).(3) While on inpatient medicine rotations:
 - IV.A.9.c).(3).(a) a first-year resident must not be assigned more than five new patients per admitting day; an additional two patients may be assigned if they are in-house transfers from the medical services; ^(Core)
 - IV.A.9.c).(3).(b) a first-year resident must not be assigned more than eight new patients in a 48-hour period; ^(Core)
 - IV.A.9.c).(3).(c) a first-year resident must not be responsible for the ongoing care of more than 10 patients; ^(Core)
 - IV.A.9.c).(3).(d) when supervising more than one first-year resident, the supervising resident must not be responsible for the supervision or admission of more than 10 new patients and four transfer patients per admitting day, or more than 16 new patients in a 48-hour period; ^(Core)
 - IV.A.9.c).(3).(e) when supervising one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 14 patients; ^(Core)
 - IV.A.9.c).(3).(f) when supervising more than one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 20 patients; ^(Core)

- IV.A.9.c).(3).(g) residents must write all orders for patients under their care, with appropriate supervision by the attending physician, exceptn those emergent circumstances when an attending physician or subspecialty resident writes an order for a resident's patient, the attending or subspecialty resident must communicate his or her action to the resident in a timely manner; ^(Core)
- IV.A.9.c).(3).(h) second- or third-year categorical internal medicine residents, or, second-, third- or fourth-year internal medicine-pediatrics residents or other appropriate supervisory physicians (e.g., fellows, or attending physicians) with documented experience appropriate to the acuity, complexity, and severity of patient illness must be available at all times on site to supervise first-year residents; ^(Core)
- IV.A.9.c).(3).(i) each physician of record has the responsibility to make management rounds on his or her patients and to communicate effectively with the residents participating in the care of these patients at a frequency appropriate to the changing care needs of the patients; ^(Core)
- IV.A.9.c).(3).(j) residents' service responsibilities must be limited to patients for whom the teaching service has diagnostic and therapeutic responsibility. (N.B.: Teaching Service is defined as those patients for whom medicine-pediatrics residents [PGY-1, -2, -3 or -4] routinely provide care); ^(Core)
- IV.A.9.c).(3).(k) residents must not be required to relate to an excessive number of attending physicians; and, ^(Core)
- IV.A.9.c).(3).(l) residents from other specialties must not supervise internal medicine-pediatrics residents on any internal medicine or pediatrics inpatient rotation. ^(Core)
- IV.A.9.d) care of adults with various illnesses in critical care units (e.g., intensive care units, cardiac care units, respiratory care units); ^(Core)
- IV.A.9.d).(1) Patient care experiences in the critical care units should occur during the first or second year and again in subsequent years. ^(Detail)
- IV.A.9.e) subspecialty experience, including exposure to neurology, that is inpatient, outpatient, or a combination of the two settings; ^(Core)

- IV.A.9.e).(1) Residents should have at least four months of subspecialty experiences. ^(Detail)
- IV.A.9.e).(2) This experience should include serving as a consultant. ^(Detail)
- IV.A.9.f) clinical experience in geriatrics; ^(Core)
- IV.A.9.f).(1) residents should have at least one geriatrics rotation. ^(Detail)
- IV.A.9.g) a maximum of two months of night float over the duration of the program, with no more than one month of night float during any one year of the program; and, ^(Core)
- IV.A.9.h) required transplant rotations in dedicated units not to exceed one month in four years. ^(Detail)
- IV.A.10. Pediatrics Component
- IV.A.10.a) A pediatric educational unit must be a block (four weeks or one month) or longitudinal experience. ^(Core)
- IV.A.10.a).(1) A longitudinal outpatient educational unit should be a minimum of 32 half-day sessions. A longitudinal inpatient educational unit should be a minimum of 200 hours. ^(Detail)
- IV.A.10.b) The pediatrics curriculum must include:
- IV.A.10.b).(1) a minimum of nine educational units of inpatient care experiences, including: ^(Core)
- IV.A.10.b).(1).(a) pediatric critical care; ^(Core)
- IV.A.10.b).(1).(a).(i) There should be one educational unit. ^(Detail)
- IV.A.10.b).(1).(b) neonatal intensive care; ^(Core)
- IV.A.10.b).(1).(b).(i) There should be two educational units. ^(Detail)
- IV.A.10.b).(1).(c) inpatient pediatrics; and, ^(Core)
- IV.A.10.b).(1).(c).(i) There should be five educational units. ^(Detail)
- IV.A.10.b).(1).(d) term newborn care. ^(Core)
- IV.A.10.b).(1).(d).(i) There should be one educational unit. ^(Detail)
- IV.A.10.b).(2) a minimum of six educational units of additional subspecialty experiences, including: ^(Core)
- IV.A.10.b).(2).(a) developmental-behavioral pediatrics; ^(Core)

IV.A.10.b).(2).(a).(i)	There should be one educational unit. ^(Detail)
IV.A.10.b).(2).(b)	adolescent medicine; and, ^(Core)
IV.A.10.b).(2).(b).(i)	There should be one educational unit. ^(Detail)
IV.A.10.b).(2).(c)	four educational units of four of the following subspecialties: ^(Core)
IV.A.10.b).(2).(c).(i)	child abuse; ^(Core)
IV.A.10.b).(2).(c).(ii)	medical genetics; ^(Core)
IV.A.10.b).(2).(c).(iii)	pediatric allergy and immunology; ^(Core)
IV.A.10.b).(2).(c).(iv)	pediatric cardiology; ^(Core)
IV.A.10.b).(2).(c).(v)	pediatric dermatology; ^(Core)
IV.A.10.b).(2).(c).(vi)	pediatric endocrinology; ^(Core)
IV.A.10.b).(2).(c).(vii)	pediatric gastroenterology; ^(Core)
IV.A.10.b).(2).(c).(viii)	pediatric hematology-oncology; ^(Core)
IV.A.10.b).(2).(c).(ix)	pediatric infectious diseases; ^(Core)
IV.A.10.b).(2).(c).(x)	pediatric nephrology; ^(Core)
IV.A.10.b).(2).(c).(xi)	pediatric neurology; ^(Core)
IV.A.10.b).(2).(c).(xii)	pediatric pulmonology; or, ^(Core)
IV.A.10.b).(2).(c).(xiii)	pediatric rheumatology. ^(Core)
IV.A.10.b).(3)	a minimum of four educational units of ambulatory experiences, including: ^(Core)
IV.A.10.b).(3).(a)	two educational units of emergency medicine (one educational unit of emergency medicine is equivalent to 160 hours); and, ^(Detail)
IV.A.10.b).(3).(a).(i)	Residents should have first-contact evaluation of pediatric patients in the Emergency Department. ^(Detail)
IV.A.10.b).(3).(b)	two educational units of ambulatory experiences, to include elements of community pediatrics and child advocacy. ^(Detail)
IV.A.10.b).(4)	two educational units as an individualized curriculum. ^(Core)

IV.A.10.b).(4).(a) The individualized curriculum should be determined by the learning needs and career plans of the resident and should be developed through the guidance of a faculty mentor. ^(Detail)

IV.B. Residents' Scholarly Activities

IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. ^(Core)

IV.B.2. Residents should participate in scholarly activity. ^(Core)

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities. ^(Detail)

V. Evaluation

V.A. Resident Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee. ^(Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. ^(Core)

V.A.1.a).(1) The program director may appoint additional members of the Clinical Competency Committee.

V.A.1.a).(1).(a) These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents in patient care and other health care settings. ^(Core)

V.A.1.a).(1).(b) Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee. ^(Core)

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee. ^(Core)

V.A.1.b).(1) The Clinical Competency Committee should:

V.A.1.b).(1).(a) review all resident evaluations semi-annually; ^(Core)

V.A.1.b).(1).(b) prepare and ensure the reporting of Milestones

evaluations of each resident semi-annually to ACGME; ^(Core)

V.A.1.b).(1).(c)

advise the program director regarding resident progress, including promotion, remediation, and dismissal. ^(Detail)

V.A.2.

Formative Evaluation

V.A.2.a)

The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment. ^(Core)

V.A.2.a).(1)

The faculty must discuss this evaluation with the resident at the completion of the assignment. ^(Core)

V.A.2.a).(2)

Residents must be evaluated utilizing a structured approach by faculty members or other appropriate supervisors using multiple assessment methods, in different settings, for: ^(Core)

V.A.2.a).(2).(a)

performing histories and physical examinations; ^(Detail)

V.A.2.a).(2).(b)

providing effective counseling of patients and families on the broad range of issues; and, ^(Detail)

V.A.2.a).(2).(c)

demonstrating the ability to make diagnostic and therapeutic decisions based on best evidence and to develop and carry out management plans. ^(Detail)

V.A.2.a).(3)

Faculty must provide verbal and written formative feedback on resident performance on at least a semiannual basis. ^(Core)

V.A.2.b)

The program must:

V.A.2.b).(1)

provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; ^(Core)

V.A.2.b).(1).(a)

This assessment should involve direct observation of resident-patient encounters. ^(Detail)

V.A.2.b).(1).(b)

The program should use an objective validated formative assessment method (e.g., in-training examination, chart stimulated recall). ^(Detail)

- V.A.2.b).(1).(b).(i) The same formative assessment method should be administered annually for each specialty. ^(Detail)
- V.A.2.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);** ^(Detail)
- V.A.2.b).(2).(a) Assessment of residents' communication skills and professionalism should include evaluations by patients and/or patients' families. ^(Detail)
- V.A.2.b).(3) document progressive resident performance improvement appropriate to educational level;** ^(Core)
- V.A.2.b).(4) provide each resident with documented semiannual evaluation of performance with feedback; and,** ^(Core)
- V.A.2.b).(5) create and document an individualized learning plan at least annually. ^(Core)
- V.A.2.b).(5).(a) The program should provide a system to assist residents in this process, including: ^(Detail)
- V.A.2.b).(5).(a).(i) faculty mentorship to help residents create learning goals; and, ^(Detail)
- V.A.2.b).(5).(a).(ii) systems for tracking and monitoring progress toward completing the individualized learning plan. ^(Detail)
- V.A.2.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.** ^(Detail)
- V.A.2.d) The record of evaluation should include a logbook or an equivalent method to document that each resident has achieved sufficient experience performing invasive procedures to achieve competence. ^(Detail)
- V.A.3. Summative Evaluation**
- V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program.** ^(Core)
- V.A.3.b) The program director must provide a summative evaluation for each resident upon completion of the program.** ^(Core)
- This evaluation must:**
- V.A.3.b).(1) become part of the resident's permanent record**

maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; ^(Detail)

V.A.3.b).(2) document the resident's performance during the final period of education; and, ^(Detail)

V.A.3.b).(3) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision. ^(Detail)

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program. ^(Core)

V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities. ^(Detail)

V.B.3. This evaluation must include at least annual written confidential evaluations by the residents. ^(Detail)

V.B.3.a) Residents must have the opportunity to provide confidential written evaluations of each teaching attending physician at the end of a rotation. ^(Core)

V.B.3.b) These evaluations must be reviewed annually with the attending physician. ^(Core)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee (PEC). ^(Core)

V.C.1.a) The Program Evaluation Committee:

V.C.1.a).(1) must be composed of at least two program faculty members and should include at least one resident; ^(Core)

V.C.1.a).(2) must have a written description of its responsibilities; and, ^(Core)

V.C.1.a).(3) should participate actively in:

V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; ^(Detail)

V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals

and objectives; ^(Detail)

V.C.1.a).(3).(c) **addressing areas of non-compliance with ACGME standards; and,** ^(Detail)

V.C.1.a).(3).(d) **reviewing the program annually using evaluations of faculty, residents, and others, as specified below.** ^(Detail)

V.C.2. **The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation.** ^(Core)

The program must monitor and track each of the following areas:

V.C.2.a) **resident performance;** ^(Core)

V.C.2.b) **faculty development;** ^(Core)

V.C.2.c) **graduate performance, including performance of program graduates on the certification examination;** ^(Core)

V.C.2.c).(1) At least 80 percent of the program's graduates from the most recently-defined three-year period must take the ABIM or the AOBIM certifying examination for the first time. ^(Outcome)

V.C.2.c).(2) At least 80 percent of the program's graduates from the most recently-defined three-year period who take the ABIM or the AOBIM certifying examination for the first time must pass. ^(Outcome)

V.C.2.c).(3) At least 70 percent of a program's graduates from the preceding five years who take the ABP certifying examination for the first time should pass. ^(Outcome)

V.C.2.c).(4) At least 70 percent of a program's graduates from the preceding five years who take the AOBP certifying examination for the first time should pass. ^(Outcome)

V.C.2.d) **program quality;** ^(Core)

V.C.2.d).(1) **Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and** ^(Detail)

V.C.2.d).(2) **The program must use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program.** ^(Detail)

V.C.2.e) **progress on the previous year's action plan(s); and,** ^(Core)

V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. ^(Core)

V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. ^(Detail)

VI. The Learning and Working Environment

Residency 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 residents today*
- *Excellence in the safety and quality of care rendered to patients by today's residents in their future practice*
- *Excellence in professionalism through faculty modeling of:*
 - *the effacement of self-interest in a humanistic environment that supports the professional development of physicians*
 - *the joy of curiosity, problem-solving, intellectual rigor, and discovery*
- *Commitment to the well-being of the students, residents, faculty members, and all members of the health care team*

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care

professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

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.

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)

VI.A.1.a).(1).(b) The program must have a structure that promotes safe, interprofessional, team-based care. (Core)

VI.A.1.a).(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

VI.A.1.a).(3) Patient Safety Events

Reporting, investigation, and follow-up of adverse 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).(3).(a) Residents, fellows, faculty members, and other clinical staff members must:

VI.A.1.a).(3).(a).(i) know their responsibilities in reporting patient safety events at the clinical site; (Core)

VI.A.1.a).(3).(a).(ii) know how to report patient safety events, including near misses, at the clinical site; and, (Core)

VI.A.1.a).(3).(a).(iii) be provided with summary information

of their institution's patient safety reports. ^(Core)

VI.A.1.a).(3).(b) Residents must participate as team members in real and/or simulated interprofessional clinical patient safety 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).(4) Resident Education and Experience in Disclosure of Adverse Events

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.

VI.A.1.a).(4).(a) All residents must receive training in how to disclose adverse events to patients and families. ^(Core)

VI.A.1.a).(4).(b) Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. ^(Detail)

VI.A.1.b) Quality Improvement

VI.A.1.b).(1) Education in Quality Improvement

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

VI.A.1.b).(1).(a) Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. ^(Core)

VI.A.1.b).(2) Quality Metrics

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

VI.A.1.b).(2).(a) Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. ^(Core)

VI.A.1.b).(3) Engagement in Quality Improvement Activities

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

VI.A.1.b).(3).(a)

Residents must have the opportunity to participate in interprofessional quality improvement activities. ^(Core)

VI.A.1.b).(3).(a).(i)

This should include activities aimed at reducing health care disparities. ^(Detail)

VI.A.2.

Supervision and Accountability

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 resident'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)

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

VI.A.2.a).(1).(a)

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

VI.A.2.a).(1).(b)

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

VI.A.2.b)

Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising

faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.

- VI.A.2.b).(1)** The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident'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.c)** **Levels of Supervision**
- To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: ^(Core)
- VI.A.2.c).(1)** **Direct Supervision – the supervising physician is physically present with the resident and patient.** ^(Core)
- VI.A.2.c).(2)** **Indirect Supervision:**
- VI.A.2.c).(2).(a)** with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. ^(Core)
- VI.A.2.c).(2).(b)** with Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. ^(Core)
- VI.A.2.c).(3)** **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.** ^(Core)
- VI.A.2.d)** **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.** ^(Core)
- VI.A.2.d).(1)** **The program director must evaluate each resident'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 residents based on the needs of the patient and the skills of each resident.** ^(Core)

- VI.A.2.d).(3)** Senior residents or fellows should serve in a supervisory role to junior 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 residents must communicate with the supervising faculty member(s). ^(Core)
- VI.A.2.e).(1)** Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. ^(Outcome)
- VI.A.2.e).(1).(a)** Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available. ^(Core)
- VI.A.2.f)** Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. ^(Core)
- VI.B. Professionalism**
- VI.B.1.** Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including 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:
- VI.B.2.a)** be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; ^(Core)
- VI.B.2.b)** be accomplished without excessive reliance on residents to fulfill non-physician obligations; and, ^(Core)
- VI.B.2.c)** ensure manageable patient care responsibilities. ^(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)
- VI.B.4.** Residents and faculty members must demonstrate an understanding of their personal role in the:
- VI.B.4.a)** provision of patient- and family-centered care; ^(Outcome)

- VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome)
- VI.B.4.c) assurance of their fitness for work, including: (Outcome)
- VI.B.4.c).(1) management of their time before, during, and after clinical assignments; and, (Outcome)
- VI.B.4.c).(2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. (Outcome)
- VI.B.4.d) commitment to lifelong learning; (Outcome)
- VI.B.4.e) monitoring of their patient care performance improvement indicators; and, (Outcome)
- VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)
- VI.B.5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Outcome)
- VI.B.6. Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

VI.C. Well-Being

In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence.

- VI.C.1. This responsibility must include:
 - VI.C.1.a) efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations,

- providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; ^(Core)
- VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts resident well-being; ^(Core)
- VI.C.1.c) evaluating workplace safety data and addressing the safety of residents and faculty members; ^(Core)
- VI.C.1.d) policies and programs that encourage optimal resident and faculty member well-being; and, ^(Core)
- VI.C.1.d).(1) Residents 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.e) attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: ^(Core)
- VI.C.1.e).(1) encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; ^(Core)
- VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, ^(Core)
- VI.C.1.e).(3) provide 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 residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work. ^(Core)

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

VI.D.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; ^(Core)

VI.D.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and, ^(Core)

VI.D.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. ^(Detail)

VI.D.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue. ^(Core)

VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. ^(Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

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

VI.E.1.a) Residents must be responsible for an appropriate patient load. Insufficient patient experiences do not meet educational needs; an excessive patient load suggests an inappropriate reliance on residents for service obligations, which may jeopardize the educational experience. ^(Core)

VI.E.2. Teamwork

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. ^(Core)

VI.E.3. Transitions of Care

VI.E.3.a) 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-over processes to facilitate both continuity of care and patient safety. ^(Core)

VI.E.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-over process. ^(Outcome)

VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care. ^(Core)

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. ^(Core)

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents 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)

The Review Committees for Internal Medicine and Pediatrics will not consider requests for exceptions to the 80-hour limit to the residents' work week.

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. ^(Core)

VI.F.2.b) Residents should have eight hours off between scheduled clinical work and education periods. ^(Detail)

VI.F.2.b).(1) There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. ^(Detail)

- VI.F.2.c)** Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. ^(Core)
- VI.F.2.d)** Residents 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**
- VI.F.3.a)** Clinical and educational work periods for residents 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 resident education. ^(Core)
- VI.F.3.a).(1).(a)** Additional patient care responsibilities must not be assigned to a resident during this time. ^(Core)
- VI.F.4.** **Clinical and Educational Work Hour Exceptions**
- VI.F.4.a)** In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:
- VI.F.4.a).(1)** to continue to provide care to a single severely ill or unstable patient; ^(Detail)
- VI.F.4.a).(2)** humanistic attention to the needs of a patient or family; or, ^(Detail)
- VI.F.4.a).(3)** to attend unique educational events. ^(Detail)
- VI.F.4.b)** These additional hours of care or education will 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.
- VI.F.4.c).(1)** In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*. ^(Core)
- VI.F.4.c).(2)** Prior to submitting the request to the Review

Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. (Core)

VI.F.5. Moonlighting

VI.F.5.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)

VI.F.5.b) Time spent by residents 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.5.c) PGY-1 residents are not permitted to moonlight. (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)

VI.F.6.a) Internal Medicine-Pediatrics residency programs must not average in-house call over a four-week period. (Core)

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

Residents 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

VI.F.8.a) Time spent on patient care activities by residents 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 resident. (Core)

VI.F.8.b) Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail)

***Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving

compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

Osteopathic Recognition

For programs seeking Osteopathic Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable.

(http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf)