

1                   **Project Program Requirements for Residency Education in Internal Medicine**  
2                                   **Educational Innovations Project (EIP)**  
3   [Common PR integrated]  
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5       **I.       Definition and Scope of Specialty**

6       Internal medicine is the discipline encompassing the study and practice of patient-  
7       centered care from adolescence to old age, during health and all stages of illness.  
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9       A renewed emphasis on clinical competency and its assessment has evolved from  
10       public interest in the safety, efficacy, and accountability of health care. These  
11       requirements are intended to facilitate innovation in residency education by highly  
12       effective programs, in order to meet societal needs and expectations for continuous  
13       improvement in both education and patient care.  
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15       **A.       Educational Standards**

- 16                   1. Residency training is primarily an educational experience in patient  
17                                   centered care.
- 18                   2. Programs with demonstrated excellence in prior accreditation reviews  
19                                   may apply to the RRC-IM to participate in the EIP
- 20                   3. Programs accepted into the EIP are expected to develop, study, and  
21                                   disseminate methods for competency-based education and evaluation.
- 22                   4. Program eligibility and requirements  
23                                   a)       Programs must have accreditation cycle length sum totalling  
24   8 over the previous 2 accreditation cycles, with the most  
25   recent cycle no less than 4 years.  
26   b)       Sponsoring institution must have “favorable/accredited  
27   status with cycle no less than 4 years  
28   c)       Programs should have a program director in place who has  
29   been either the program director or associate program  
30   director of that program for at least 4 years, and have  
31   managed the accreditation review of that program for at  
32   least 1 accreditation visit.  
33   d)       Institutional leadership must be committed to this pilot  
34   project, which inextricably links the quality education in  
35   Internal Medicine to the quality of patient centered care.  
36   Sponsoring institutions must demonstrate commitment  
37   through formal resolution of the governing board, agreed to  
38   by the administrative leadership of the sponsor, the GMEC,  
39   the department, and the program. Further, this commitment  
40   must agree to provide resources sufficient to provide quality  
41   patient centered care, to provide integrated information  
42   systems for clinical care and evaluation of quality, to  
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support the faculty and residents in their clinical and educational missions, and demonstrate the willingness to foster interdisciplinary teamwork and modify systems of care and education to enhance the quality of care and education.

- e) Programs must agree to annual resident survey completion
- f) Programs must agree to submit annual reports of outcomes measures and program modifications as required in these requirements on an annual basis, reviewed and validated by the GMEC and the DIO.
- g) The leadership of the program must agree to convene annually in conjunction with a national meeting of the Association of Program Directors in Internal Medicine.
- h) Programs must agree to disseminate their educational innovations in program design or outcomes measurement through presentations at the scientific abstract sessions of Association of Program Directors in Internal Medicine, the Accreditation Council for Graduate Medical Education, the Society of General Internal Medicine, the American College of Physicians, or other groups whose mission is the advancement of education of residents in Internal Medicine. Copies of these abstracts should be submitted to the RRC on an annual basis with outcomes reporting.
- i) The Pilot Project can extend the accepted programs' accreditation cycle lengths for up to 10 years or the length of the project.
- j) Programs may be removed from the Pilot Project by the RRC-IM based on the RRC-IM's assessment of the breadth and effectiveness of the use of outcomes measures to enhance the quality of patient centered care and education of residents, the results of targeted site visits, or other breaches of these program requirements.
- k) Upon removal by the RRC-IM, or by voluntary removal from the project, the program will continue its previous accreditation status, the RRC-IM will establish an accreditation cycle length and date for the next site visit based on the Pilot Project Accreditation Standards.

92 **B. Duration and Scope of Education**

- 93
- 94 1. An accredited residency program in internal medicine must provide
- 95 36 months of supervised graduate education in the domain of
- 96 internal medicine.
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- 98 2. Over the 36 months of training, residents must develop a long term
- 99 healing relationship with general internal medicine patients.
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- 101 3. The residency program must ensure that residents achieve
- 102 competence in patient care, medical knowledge, practice-based
- 103 learning, interpersonal and communication skills, professionalism,
- 104 and system-based practice (the Competencies) needed to practice
- 105 internal medicine.
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- 107 4. The internal medicine component of special educational tracks must
- 108 be conducted under the auspices of the Department of Internal
- 109 Medicine.
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111 **II. Institutional Support**

112 **A. Sponsoring Institution**

113 **One sponsoring institution must assume the ultimate responsibility for**

114 **the program as described in the Institutional Requirements, and this**

115 **responsibility extends to resident assignments at all participating**

116 **institutions.** The leadership must demonstrate that there is an institutional

117 culture of continuous improvement in quality of patient care and education.

118 Systems must be present at the institutional level to support, nurture, and

119 enhance quality of patient care and educational programs. The sponsoring

120 institution

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- 124 1. must demonstrate a commitment to quality patient centered care,
- 125 education, and scholarship sufficient to support the residency
- 126 program;
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- 128 2. must provide resident compensation and benefits, faculty, facilities,
- 129 and resources for patient centered clinical care, education, and
- 130 scholarship required for accreditation;
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- 132 3. must designate and support a single program director within the
- 133 internal medicine administrative unit with the qualifications and
- 134 appropriate authority defined in Section II B;
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- 136 4. should provide at least 75% salary support for the program director;
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5. must provide 20 hours per week salary support for each associate program director (APD) required to meet these Program Requirements;
  6. must provide salary support for one program administrator, and secretarial/clerical support sufficient for the operation of the program;
  7. must provide systems, processes and resources to measure and improve patient care and education in the department of medicine;
  8. must notify the RRC within 30 days of:
    - a) a change in departmental leadership;
    - b) a change in the program director. The qualifications and the curriculum vitae of the new program director must be submitted to the RRC;
    - c) changes in institutional governance or affiliation;
    - d) changes in resources that adversely affect the delivery of quality patient centered care or the educational program, or prevent fulfillment of the requirements for participation in the Pilot Project for Accreditation in Internal Medicine.

163 **B. Participating Institutions**

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1. **Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.**
  2. **Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:**
    - a) **identify the faculty who will assume both educational and supervisory responsibilities for residents;**
    - b) **specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**
    - c) **specify the duration and content of the educational experience; and**

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- d) **state the policies and procedures that will govern resident education during the assignment.**

188 **III. Program Personnel and Resources**

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190 **A. Program Director**

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- 1. **There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either program director or department chair, the program director should promptly notify the executive director of the RRC through the Web Accreditation Data System of the ACGME.**
  - 2. **The program director, together with the faculty, is responsible for the general administration of the program, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an appropriate continuity of leadership.**
  - 3. **Qualifications of the program director are as follows:**
    - a) **The program director must possess the requisite specialty expertise, as well as documented educational and administrative abilities.**
    - b) **The program director must be certified in by the American Board of Internal Medicine, or possess qualifications judged to be acceptable by the RRC**
    - c) **The program director must be appointed in good standing and based at the primary teaching site.**
    - d) **The length of appointment for the program director should provide for continuity of leadership.**
  - 4. **Responsibilities of the program director are as follows:**
    - a) **The program director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a**

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**local site director, and monitoring appropriate resident supervision at all participating institutions.**

- b) The program director is responsible for preparing an accurate statistical and narrative description of the program as requested by the RRC, as well as updating annually both program and resident records through the ACGME's Accreditation Data System.**
- c) The program director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.**
- d) The program director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the residents. Such changes, for example, include:
  - (1) the addition or deletion of a participating institution;**
  - (2) a change in the format of the educational program;**
  - (3) a change in the approved resident complement.****

**On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.**

- e) should dedicate no less than 75% (at least 30 hours per week) of his or her professional effort to the administrative and educational activities of the internal medicine educational program and receive institutional support for this time.**
- f) must be primarily responsible and have appropriate authority for the organization, implementation, and supervision of all aspects of the training program, including assuring the quality of the patient centered educational experiences of residents, selection and supervision of teaching faculty and other program personnel at each institution participating in the program.**

- 275 g) must participate in departmental and institutional clinical  
276 quality improvement programs, and integrate this  
277 information in the organization of the educational program.  
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- 279 h) must prepare written educational goals and objectives of the  
280 program, for each level of training and for each major  
281 rotation or other program assignments. These goals should  
282 be organized according to the Competencies.  
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- 284 i) Monitoring any internal medicine subspecialty training  
285 programs sponsored by the institution to ensure compliance  
286 with the ACGME accreditation standards.  
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- 288 j) Having supervisory authority over all educational tracks in  
289 the internal medicine residency program.  
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291 **B. Faculty**

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- 293 **1. At each participating institution, there must be a sufficient**  
294 **number of faculty with documented qualifications to instruct**  
295 **and supervise adequately all residents in the program.**  
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- 297 **2. The faculty, furthermore, must devote sufficient time to the**  
298 **educational program to fulfill their supervisory and teaching**  
299 **responsibilities. They must demonstrate a strong interest in the**  
300 **education of residents, and must support the goals and**  
301 **objectives of the educational program of which they are a**  
302 **member.**  
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- 304 **3. Qualifications of the physician faculty are as follows:**  
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- 306 a) **The physician faculty must possess the requisite**  
307 **specialty expertise and competence in clinical care and**  
308 **teaching abilities, as well as documented educational and**  
309 **administrative abilities and experience in their field.**  
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- 311 b) **The physician faculty must be certified in the specialty**  
312 **by the American Board of Internal Medicine, or possess**  
313 **qualifications judged to be acceptable by the RRC.**  
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- 315 c) **The physician faculty must be appointed in good**  
316 **standing to the staff of an institution participating in the**  
317 **program.**  
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- 319 d) **The physician faculty must be licensed to practice medicine**  
320 **in the state where the sponsoring institution is located or the**

321 major teaching activity occurs. (Certain federal programs  
322 are exempted.)

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324 e) The physician faculty must meet professional standards of  
325 ethical behavior.

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327 **4. The responsibility for establishing and maintaining an**  
328 **environment of inquiry and scholarship rests with the faculty,**  
329 **and an active research component must be included in each**  
330 **program. Scholarship is defined as the following:**

- 331  
332 a) **the scholarship of discovery, as evidenced by peer**  
333 **reviewed funding or by publication of original research**  
334 **in a peer reviewed journal;**  
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336 b) **the scholarship of dissemination, as evidenced by review**  
337 **articles or chapters in textbooks;**  
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339 c) **the scholarship of application, as evidenced by the**  
340 **publication or presentation of, for example, case reports**  
341 **or clinical series at local, regional, or national**  
342 **professional and scientific society meetings.**

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344 **Complementary to the above scholarship is the regular**  
345 **participation of the teaching staff in clinical discussions, rounds,**  
346 **journal clubs, and research conferences in a manner that**  
347 **promotes a spirit of inquiry and scholarship (e.g., the offering**  
348 **of guidance and technical support for residents involved in**  
349 **research such as research design and statistical analysis); and**  
350 **the provision of support for residents' participation, as**  
351 **appropriate, in scholarly activities. Although not all faculty**  
352 **members must be investigators, collectively their activity must**  
353 **include all of the elements outlined above.**

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355 **5. Qualifications of the nonphysician faculty are as follows:**

- 356  
357 a) **Nonphysician faculty must be appropriately qualified in**  
358 **their field.**  
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360 b) **Nonphysician faculty must possess appropriate**  
361 **institutional appointments.**

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363 **C. Other Program Personnel**

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365 **Additional professional, technical, and clerical personnel must be**  
366 **provided to support the program.**

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1. Associate program directors

Associate program directors (APD's) must be ABIM certified faculty who assist the program director in the administrative and clinical oversight of the educational program. Sponsoring organizations must provide associate program directors sufficient for program size.

- a) **Qualifications.** Associate Program Directors must be clinicians with broad knowledge of, experience with, and commitment to internal medicine as a discipline, patient centered care, and to the generalist training of residents.
- b) **Responsibilities.** Associate program directors must dedicate an average of at least 20 hours per week to the administrative and educational aspects of the educational program as delegated by the program director and receive institutional support for this time;

2. Subspecialty education coordinators

- a) **Qualifications.** In conjunction with division chiefs, the program director must identify a qualified individual (subspecialty education coordinator) in each of the subspecialties of internal medicine (cardiology, critical care, endocrinology, hematology, gastroenterology, geriatric medicine, infectious diseases, nephrology, oncology, pulmonary disease, and rheumatology). The subspecialty education coordinator must be ABIM certified in the subspecialty or possess qualifications judged by the RRC to be acceptable.
- b) **Responsibilities.** The subspecialty education coordinator must dedicate an adequate portion of his or her professional effort throughout the year to the internal medicine training program to accomplish the educational goals in each subspecialty.

3. Site coordinating faculty

At each participating institution where residents spend 6 or more months, the sponsor must ensure that a designated faculty member coordinates the activities of the residents. This faculty member must be based at that participating institution, and assure the quality of the patient centered educational experiences of residents. The site

413 coordinating faculty member must participate in departmental and  
414 institutional clinical quality improvement programs, integrate this  
415 information in the organization of the educational program at that  
416 site, and report to the program director  
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418 **D. Resources**

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420 **1. The program must ensure that adequate resources (e.g.,**  
421 **sufficient laboratory space and equipment, computer and**  
422 **statistical consultation services) are available.**  
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424 2. The sponsoring institution must assure that the broad range of  
425 facilities, medical staff, and support staff required to provide  
426 services for the comprehensive care of adult patients are assembled  
427 and functioning. Residents must have clinical experiences in  
428 efficient, effective ambulatory and inpatient care settings.  
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430 3. Adequate teaching space must be available.  
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432 4. Residents must have sleeping rooms, lounge, and food facilities  
433 during assigned duty hours.  
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435 5. When residents are assigned night duty in the hospital, they must be  
436 provided with on-call facilities that are convenient and that afford  
437 privacy, safety, and a restful environment with a secure space for  
438 their belongings.  
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440 6. Medical Records  
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442 Clinical records that document both inpatient and ambulatory care  
443 must be readily available at all times. Residents should have access  
444 to an integrated electronic health record in both inpatient and  
445 ambulatory care areas. In the absence of an existing integrated  
446 electronic health record, programs must demonstrate institutional  
447 commitment to its development, and progress towards its  
448 implementation.  
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450 7. Medical Reference Material  
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452 a) There must be a means of access to an on-site library or to  
453 reference material (print or electronic) in each participating  
454 institution at all times.  
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456 b) Residents must have ready access to a computerized  
457 literature search system and electronic medical databases at  
458 all times.

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- 8. Patient Population
  - a) The patient population must have a variety of clinical problems and stages of disease
  - b) There must be patients of both sexes, with a broad age range, including geriatric patients.

**IV. Resident Appointment**

**A. Eligibility Criteria**

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

**B. Number of Residents**

**The RRC will prospectively approve the number of residents based upon established written criteria that include the adequacy of resources for resident education (e.g., the quality and volume of patients and related clinical material available for education), faculty resident ratio, institutional funding, and the quality of faculty teaching.**

**C. Resident Transfer**

**To determine the appropriate level of education for residents who are transferring from another residency program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation, including an assessment of Competence, of the transferring resident prior to their acceptance into the program, prior to acceptance into the program. A program director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.**

**D. Appointment of Fellows and Other Students**

**The appointment of fellows, other specialty residents, or students must not dilute or detract from the educational opportunities of internal medicine residents.**

**V. Program Curriculum**

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**A. Program Design**

**1. Format**

**The program design and sequencing of educational experiences will be approved by the RRC as part of the accreditation process.**

**2. Goals and Objectives**

**The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of residents for each major assignment and for each level of the program. This statement must be distributed to residents and faculty, and must be reviewed with residents prior to their assignments.** For each rotation or major learning experience, the written curriculum must contain the goals and objectives, educational methods, and methods of evaluation of the competencies.

**B. Specialty Curriculum**

**The program must possess a well-organized and effective curriculum, both didactic and clinical. The curriculum must also provide residents with direct experience in progressive responsibility for patient management.**

**C. Residents Scholarly Activities**

**Each program must provide an opportunity for residents to participate in research or other scholarly activities, and residents must participate actively in such scholarly activities.**

**D. ACGME Competencies**

**The residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:**

- 1. *Patient care* that is compassionate, appropriate, and effective for the treatment of health programs and the promotion of health;**

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2. ***Medical knowledge*** about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;
3. ***Practice-based learning and improvement*** that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;
4. ***Interpersonal and communication skills*** that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;
5. ***Professionalism***, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;
6. ***Systems-based practice***, as manifested by actions that 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.

**E. Patient Centered Education**

The educational efforts of faculty and residents in the context of interactions with their patients should be designed to enhance the quality of patient care, and the education of the residents.

1. Patient centered care and resident education must be integrated. On all assignments, residents and faculty must regularly interact in patient centered care. These interactions must include:
  - a) resident and attending interaction with the patient
  - b) demonstration of interview and physical examination techniques
  - c) discussion of the pathophysiology,
  - d) use of current evidence in diagnostic and therapeutic decisions,
  - e) use of measures of quality to improve care

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2. The program must describe the educational goals of the patient centered education program to faculty and residents, and demonstrate, through outcomes assessment, the effectiveness and improvement of the program's educational outcomes.
  3. Residents should have experience in the care of patients as members of multidisciplinary teams of health providers in all setting.
  4. The Program Requirements for Residency Education in Internal Medicine provide guidelines for patient encounters.
  5. Second- and third-year internal medicine residents must supervise first year internal medicine residents as an important component of the senior resident's professional development
  6. Second- or third-year internal medicine residents, or other appropriate supervisory physicians (eg, subspecialty residents or attendings) 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.
  7. There must be a resident duty schedule.
  8. The duty schedule must include a plan for backup to ensure that patient care is not jeopardized during or following assigned periods of duty.
  9. The program must articulate rigorous sign-out and sign-in procedures to ensure effectiveness of patient care, and demonstrate, through outcomes assessment, the effectiveness of the program's sign-out systems.

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**F. Structured Educational Experiences**

These experiences (such as, but not limited to conferences, small group sessions, simulations) complement the patient centered educational program, and provide the opportunity to build a professional community, assure that residents benefit from the range of the faculty expertise, to learn to teach from expert teachers and each other, and to reflect on the effectiveness of care of their patients. The program must describe the educational goals of these experiences to faculty and residents, and demonstrate, through outcomes assessment, their effectiveness.

**G. Ambulatory medicine**

Over the 36 months of training, residents must develop a long term healing relationship with general internal medicine patients. The program must describe the educational goals of these experiences to faculty and residents, and demonstrate, through outcomes assessment, their effectiveness.

**H. Emergency Medicine**

Internal medicine residents must have first-contact responsibility for a sufficient number of undifferentiated acutely and severely ill patients to meet the educational needs of internal medicine residents. The program must describe the educational goals of these experiences to faculty and residents, and demonstrate, through outcomes assessment, their effectiveness.

**I. Inpatient medicine**

1. On inpatient assignments, new and established patient encounters must be sufficient to assure the development of clinical competence in the care of patient with the spectrum of clinical disorders in internal medicine, while allowing residents sufficient time to evaluate each patient, to develop healing relationships with patients and families, to learn from their patient interactions. Inpatient rotations must provide each resident with supervised autonomy that delivers quality care and assures patient safety.
2. Inpatient medicine — Critical Care
  - a) Residents must be assigned to critical care rotations.



720 Providing residents with a sound didactic and clinical education must be  
721 carefully planned and balanced with concerns for patient safety and resident  
722 well-being. Each program must ensure that the learning objectives of the  
723 program are not compromised by excessive reliance on residents to fulfill  
724 service obligations. Didactic and clinical education must have priority in the  
725 allotment of residents' time and energy. Duty hour assignments must  
726 recognize that faculty and residents collectively have responsibility for the  
727 safety and welfare of patients.

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729 **A. Supervision of Residents**

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731 1. All patient care must be supervised by qualified faculty. The  
732 program director must ensure, direct, and document adequate  
733 supervision of residents at all times. Residents must be  
734 provided with rapid, reliable systems for communicating with  
735 supervising faculty.  
736  
737 2. Faculty schedules must be structured to provide residents with  
738 continuous supervision and consultation.  
739  
740 3. Faculty and residents must be educated to recognize the signs of  
741 fatigue, and adopt and apply policies to prevent and counteract  
742 its potential negative effects.  
743

744 **B. Duty Hours**

- 745  
746 1. Duty hours are defined as all clinical and academic activities  
747 related to the residency program; i.e., patient care (both  
748 inpatient and outpatient), administrative duties relative to  
749 patient care, the provision for transfer of patient care, time  
750 spent in-house during call activities, and scheduled activities  
751 such as conferences. Duty hours do *not* include reading and  
752 preparation time spent away from the duty site.  
753  
754 2. Duty hours must be limited to 80 hours per week, averaged over  
755 a four-week period, inclusive of all in-house call activities.  
756  
757 3. Residents must be provided with 1 day in 7 free from all  
758 educational and clinical responsibilities, averaged over a 4-week  
759 period, inclusive of call. *One day* is defined as 1 continuous  
760 24-hour period free from all clinical, educational, and  
761 administrative duties.  
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763 4. Adequate time for rest and personal activities must be  
764 provided. This should consist of a 10-hour time period  
765 provided between all daily duty periods and after in-house call.

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**C. On-Call Activities**

**The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.**

- 1. In-house call must occur no more frequently than every third night.**
- 2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.**
- 3. No new patients may be accepted after 24 hours of continuous duty. A new patient is defined as any patient to whom the resident has not previously provided care.**
- 4. *At-home call (or pager call)* is defined as a call taken from outside the assigned institution.
  - a) The frequency of at-home call is not subject to the every-third- night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.**
  - b) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.**
  - c) The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.****

**D. Moonlighting**

- 1. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not**

812 interfere with the ability of the resident to achieve the goals and  
813 objectives of the educational program.

- 814
- 815 **2. The program director must comply with the sponsoring**  
816 **institution's written policies and procedures regarding**  
817 **moonlighting, in compliance with the ACGME Institutional**  
818 **Requirements.**
  - 819
  - 820 **3. Any hours a resident works for compensation at the sponsoring**  
821 **institution or any of the sponsor's primary clinical sites must be**  
822 **considered part of the 80-hour weekly limit on duty hours. This**  
823 **refers to the practice of *internal moonlighting*.**

824

825 **E. Oversight**

- 826
- 827 **1. Each program must have written policies and procedures**  
828 **consistent with the Institutional and Program Requirements for**  
829 **resident duty hours and the working environment. These**  
830 **policies must be distributed to the residents and the faculty.**  
831 **Duty hours must be monitored with a frequency sufficient to**  
832 **ensure an appropriate balance between education and service.**
  - 833
  - 834 **2. Back-up support systems must be provided when patient care**  
835 **responsibilities are unusually difficult or prolonged, or if**  
836 **unexpected circumstances create resident fatigue sufficient to**  
837 **jeopardize patient care.**
  - 838
  - 839 **3. A sponsoring institution must not place excessive reliance on**  
840 **residents to meet the service needs of the participating training**  
841 **sites.**

842

843 **F. Duty Hour Exception**

844

845 **The RRC for Internal Medicine will not consider requests for**  
846 **exceptions to the limit to 80 hours per week, averaged monthly.**

847

848 **G. Graded Responsibility**

- 849
- 850 **1. The responsibility given to residents in patient care should depend**  
851 **upon each resident's knowledge, problem-solving ability, manual**  
852 **skills, experience, and the severity and complexity of each patient's**  
853 **status.**
  - 854
  - 855 **2. Each resident must be assigned at least 24 months of the 36 months**  
856 **of patient centered residency education in settings where the**

857 resident personally provides, or supervises junior residents who  
858 provide, direct patient care in inpatient or ambulatory settings.  
859

## 860 VII. Evaluation

### 861 A. Resident

#### 862 1. Formative Evaluation

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864 **The faculty must evaluate in a timely manner the residents**  
865 **whom they supervise. In addition, the residency program must**  
866 **demonstrate that it has an effective mechanism for assessing**  
867 **resident performance throughout the program, and for utilizing**  
868 **the results to improve resident performance. The resident must**  
869 **be closely observed performing specific tasks of patient**  
870 **management such as the interview and physical examination, choice**  
871 **of diagnostic studies, formulation of differential diagnosis or**  
872 **problem lists, development of plans for short-term and long-term**  
873 **medical management, communication of treatment plans, invasive**  
874 **procedures, and (when on inpatient services) discharge planning.**  
875  
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877

878 a) **Assessment should include the use of methods that**  
879 **produce an accurate assessment of residents' competence**  
880 **in patient care, medical knowledge, practice-based**  
881 **learning and improvement, interpersonal and**  
882 **communication skills, professionalism, and**  
883 **systems-based practice. The program must evaluate each**  
884 **resident on each rotation with at least 2 evaluation tools.**  
885 **One tool should be a global competency based evaluation,**  
886 **and one should be an evaluation tool designed to**  
887 **specifically evaluate one or more of competencies in depth.**  
888

889 b) **Assessment should include the regular and timely**  
890 **(usually once per month) performance feedback to**  
891 **residents, and that also includes at least semiannual**  
892 **written evaluations. Such evaluations are to be**  
893 **communicated to each resident in a timely manner and**  
894 **maintained in a record that is accessible to each resident.**  
895

896 c) **Assessment should include the use of assessment results,**  
897 **including evaluation by faculty, patients, peers, self,**  
898 **nurses and other professional staff to achieve**  
899 **progressive improvements in residents' competence and**  
900 **performance.**  
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#### 902 2. Final (Summative) Evaluation

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**The program director must provide a final evaluation for each resident who completes the program. (N.B.: This summative evaluation is in addition to the completion of the ABIM tracking form.) The evaluation must include a review of the resident's performance during the final period of education and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record maintained by the institution.**

**B. Faculty**

1. **The performance of the faculty must be evaluated by the program annually. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, quality of patient centered care, and scholarly activities. This evaluation must include annual written confidential evaluations by residents. Residents must confidentially provide written evaluations of each teaching attending at the end of a rotation, and for the evaluations to be reviewed annually with faculty.**
2. The results of the evaluations must be used for faculty-member counseling and for selecting faculty members for specific teaching assignments.

**C. Program**

**The educational and patient-centered clinical effectiveness of a program must be evaluated at least annually in a systematic manner. The residents must confidentially evaluate the educational and clinical effectiveness of the program at least annually.**

1. **Representative program personnel (i.e., at least the program director, representative faculty and departmental leadership, and one resident) must be organized to review program educational and clinical goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution, and the residents' annual confidential written evaluations, and assessments of clinical effectiveness. If deficiencies are found, the group should prepare an explicit plan of action, which**

949 should be approved by the faculty and documented in the  
950 minutes of the meeting.

- 951
- 952 **2. The program should use resident performance and outcome**  
953 **assessment in its evaluation of the educational and clinical**  
954 **effectiveness (patient outcomes) of the residency program.**  
955 **Performance of program graduates on the certification**  
956 **examination should be used as one measure of evaluating**  
957 **program effectiveness. The program should maintain a process**  
958 **for using assessment of educational and clinical results together**  
959 **with other program evaluation results to improve the residency**  
960 **program.**
- 961
- 962 **3. During participation in the pilot project the Graduate Medical**  
963 **Education Committee will review the effectiveness of the program**  
964 **every two years. It is desirable that feedback from patients,**  
965 **professional and non-professional staff members, practice**  
966 **performance data for program graduates, and faculty and residents**  
967 **from other departments of the effectiveness of the delivery of**  
968 **patient centered services be included in this evaluation.**

969

970 **VIII. Experimentation and Innovation**

- 971
- 972 **A. Since responsible innovation and experimentation are essential to**  
973 **improving professional education, experimental projects along sound**  
974 **educational principles are encouraged. Requests for experimentation**  
975 **or innovative projects that may deviate from the program**  
976 **requirements must be approved in advance by the RRC, and must**  
977 **include the educational rationale and method of evaluation. The**  
978 **sponsoring institution and program are jointly responsible for the**  
979 **quality of education offered to residents for the duration of such a**  
980 **project.**

981

982 **B. Performance Improvement Process**

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- 984 **1. The program should identify and participate in at least 3 ongoing**  
985 **performance improvement (PI) activities which relate to the**  
986 **competencies.**
- 987
- 988 **2. The PI activities must involve both residents and faculty in planning**  
989 **and implementing.**
- 990
- 991 **3. The PI activities should result in measurable improvements in**  
992 **patient care or residency education.**

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**IX. Certification**

**Residents who plan to seek certification by the American Board of Internal Medicine should communicate with the registration section of the board regarding fulfillment of requirements for certification.** Residents must be certified in internal medicine prior to seeking certification in a subspecialty.

- A. A program's graduates must achieve a pass rate on the certifying examination of the ABIM of at least 80% for first-time takers of the examination for the most recently defined 3-year period.
- B. At least 80% of those completing their training in the program for the most recently defined 3-year period must have taken the certifying examination.