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### COMMON PROGRAM REQUIREMENTS, AND RESIDENTS DEFINED AS “INTERMEDIATE-LEVEL” OR IN THEIR “FINAL YEARS OF EDUCATION”

The Review Committee provided specialty-specific definitions for the following new Common Program Requirements: (a) *Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.* (Program Requirement VI.G.5.b)); and (b) *Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.* (Program Requirement VI.G.5.c)).

The Review Committee determined that no internal medicine residents are considered “intermediate-level residents.” PGY-2 and PGY-3 residents and all fellows are considered to be “in the final years of education.” PGY-2 residents in combined Internal Medicine-Pediatrics programs are considered “intermediate-level residents” and PGY-3 and PGY-4 residents in these programs are considered as being “in the final years of education.”

### NEW FAQs

At its fall 2010 and May 2011 meetings, the Review Committee developed several FAQs. The final versions of these will be added to the FAQ document available on the Review Committee web page in the near future, but provided here are two important FAQs related to core program requirements:

**Question:** What does the Review Committee consider to be “night medicine” and how does it relate to “night float”? [Program Requirement I.A.2.m).(4)]

**Answer:** “Night medicine” is defined as a rotation of two or more consecutive nights of inpatient clinical duty which includes the following:

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#### MEETING AND AGENDA CLOSING DATES

MEETING:	JANUARY 26-29, 2012
AGENDA CLOSING:	NOVEMBER 4, 2011
MEETING:	MAY 17-20, 2012
AGENDA CLOSING:	FEBRUARY 24, 2012
MEETING:	SEPTEMBER 20-23, 2012
AGENDA CLOSING:	JUNE 29, 2012

#### NOTIFICATION DEADLINES

##### 5 DAYS AFTER MEETING:

E-MAIL NOTIFICATION OF REVIEW STATUS/  
CYCLE LENGTH AUTOMATICALLY SENT TO  
PROGRAM DIRECTOR AND DIO.

##### 60 DAYS AFTER MEETING:

E-MAIL ALERT SENT STATING THAT LETTER  
OF NOTIFICATION IS POSTED IN ADS.

\*UNTIL THE OFFICIAL LETTER IS POSTED IN ADS, REVIEW COMMITTEE STAFF MEMBERS ARE UNABLE/NOT PERMITTED TO DISCUSS THE COMMITTEE'S ACTION OR SPECIFIC DETAILS OF THE AREAS OF NON-COMPLIANCE.\*

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- faculty interaction that allows for meaningful evaluation of resident performance, including the opportunity for bedside teaching and observation of direct patient care;
- interaction with the patient's primary daytime physicians;
- a predefined cohort of patients for which the resident is responsible;
- input into the ongoing care of the patient during his/her hospitalization;
- a defined curriculum with Goals and Objectives; and,
- accessibility of consultants (in person or by phone).

This applies to all hospital inpatient floor rotations. Emergency Department rotations are not included. If these criteria are met for night duty on ICU rotations, then the night duty counts towards ICU time and not towards "night medicine." The annual and total limits of "night float" as designated in the program requirements will not change: "night float" must not exceed two months per year nor more than four months across the three years of residency. However, programs can extend the sum of "night float" and "night medicine" to five months over the three year residency. Programs are encouraged to incorporate the criteria mentioned above for "night medicine" into all night duty experiences (Dated: 5/2011).

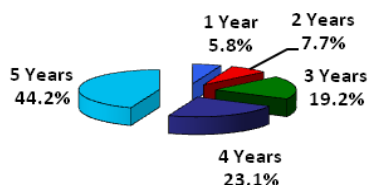
*Question:* Can a non-internist serve as a faculty preceptor in continuity clinic? [Common Program Requirement: II.A.4.c]

*Answer:* The Review Committee allows the program director, under rare circumstances, to appoint an experienced non-internist with special expertise to supervise in ambulatory setting (e.g. a family medicine physician with extensive ambulatory experience, procedural or other pertinent training). It is expected that the site director for each continuity clinic be an internist and the vast majority of preceptors be internists (Dated: 10/2010).

## SUMMARY OF ACTIONS TAKEN IN 2010

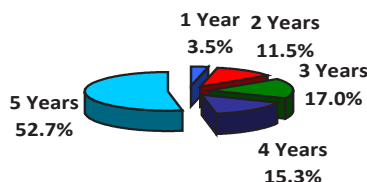
The Review Committee reviewed 72 core and 474 fellowships in 2010. The charts below provide a summary of the actions taken and review cycles granted.

Number of Core Internal Medicine Programs Reviewed	72
Initial Accreditation	4
Continued Accreditation	52
Proposed Probation	1
Probation	1
Progress Reports	11
Voluntary Withdrawal	3



- The vast majority of core programs reviewed in 2010 (67.3%) received a 4- or a 5-year cycle.
- A very small percentage of programs received a 1-year cycle (5.8%).
- Only one program received a proposed adverse action.
- Only one program was put on probation.

Number of Subspecialty Programs Reviewed	474
Initial Accreditation	29
Continued Accreditation	347
Proposed Withhold	15
Withhold	4
Voluntary Withdrawal	32
Progress Reports	45
Duty Hour Reports	2



- The vast majority of fellowship programs reviewed in 2010 (68%) received a 4- or a 5-year cycle.
- A small percentage of programs (3.2%) received a proposed adverse actions.

A review of the notification letters for applications that received a proposed or confirmed withhold of accreditation action (n=19) revealed that most contained the following citations:

- inadequate faculty scholarship (participation and/or productivity)
- no evidence that key clinical faculty had current ABIM certification
- inadequate core conferences

The tables that follow summarize the most frequent areas of non-compliance for core and fellowship programs for 2010 (January–December).

**72 Core Programs Reviewed in 2010**  
**Total of 284 Citations = 3.9 citations/program**

Name and Description of Citations	Times Cited
<b>1. Curricular Development</b> - inadequate continuity experience; inadequate opportunities w/procedures; excessive # of physicians of record; no competency-based goals and objectives; inadequate exposure in subspecialties	<b>26</b>
<b>2. Other Program Personnel</b> - subspecialty education coordinator(s) not certified; MICU director not certified; consultations from other clinical services not provided in a timely manner; inadequate # of other health care professionals	<b>25</b>
<b>3. Evaluation of Residents</b> - semiannual evaluation not documented; faculty do not routinely provide verbal feedback at the end of a rotation; inadequate summative evaluation; evaluations not competency-based; inadequate multi-source evaluation	<b>25</b>
<b>4. Evaluation of Program</b> - no action plan to address deficiencies; residents not included in annual review of the program; faculty development not tracked and monitored; does not share faculty performance data; no formal systematic review of the program	<b>21</b>
<b>5. Institutional Support</b> - internal review did not occur mid-cycle; no program letter of agreement; internal review committee does not include all required components; environment of fear/intimidation; program not in department of medicine	<b>18</b>
<b>6. Service to Education Imbalance</b> - excessive reliance on residents to meet service needs; inadequate teaching ratio; PGY-3 has the ongoing care of more than 20 patients; PGY-1 has the ongoing care of more than 10 patients; service responsibilities not limited to patients on the teaching service	<b>17</b>
<b>7. Responsibilities of Program Director</b> - inadequate oversight of subspecialties; no mechanism to monitor duty hours; inadequate/inaccurate PIF; inadequate faculty supervision; inadequate oversight of all sites; more than eight learners on rounds w/residents	<b>16</b>
<b>8. Patient Care Experience</b> - inadequate patient population; residents don't write all patient care orders; insufficient opportunity to follow a panel of patients; insufficient ambulatory time; inadequate geriatric medicine experience; inadequate neurology experience; interruption of continuity clinic	<b>14</b>
<b>9. Supervision</b> - inadequate supervision in intensive care units; inadequate on-site supervision of first-year residents	<b>13</b>
<b>10. On-call Rooms</b> - inadequate on-call facilities; inadequate food facilities	<b>12</b>

(continued on p.4)

**Save the Date:**  
**2012 ACGME**  
**Annual Educational Conference**

**March 1-4, 2012**

Walt Disney World Swan and Dolphin  
 Orlando, Florida

*\*\*more information to follow\*\**

**474 Subspecialty Programs Reviewed in 2010**  
**Total of 1,027 Citations = 2.2 citations/program**

Name and Description of Citations	Times Cited
<b>1. Evaluation of Fellows</b> - semiannual evaluation not documented; faculty members do not routinely provide verbal feedback at end of rotation; inadequate multi-source evaluation; fellows' performance in continuity clinic not documented; appropriate evaluation methods not used to evaluate fellows' achievement of the competencies; inadequate procedure logs; no summative evaluation	<b>187</b>
<b>2. Didactic Components</b> - fellows not educated to recognize signs of fatigue and sleep deprivation; no regularly-scheduled or -attended research conference; five hours of teaching rounds per week do not occur; instruction for basic sciences not provided	<b>135</b>
<b>3. Evaluation of the Program</b> - program evaluation did not address all required elements; does not monitor and track program quality; no written improvement plan	<b>92</b>
<b>4. Patient Care Experience</b> - inadequate continuity clinic experience and/or continuity clinic patient volume; panel of patients does not include 25% of each gender; inadequate procedural experience(s)	<b>75</b>
<b>5. Responsibilities of the Program Director</b> - does not oversee/ensure the quality of education at all participating sites; unapproved changes in complement; no CME for the program director; inaccurate PIF; unfamiliar with the ACGME policies and procedures; no reporting relationship with the internal medicine program director; program director not at primary site; places undesirable stress on fellows	<b>70</b>
<b>6. Goals and Objectives</b> - no evidence of level-specific and competency-based goals and objectives for each assignment	<b>64</b>
<b>7. Institutional Support</b> - internal review did not occur mid-cycle; inadequate faculty support; inadequate faculty, facilities, and/or resources; no PLA; incomplete internal review committee	<b>58</b>
<b>8. Evaluation of Faculty</b> - faculty member evaluations by fellows is not confidential; faculty member are not evaluated at the end of each rotation/assignment; faculty members not evaluated semi-annually and/or annually	<b>40</b>
<b>9. Responsibilities of Faculty</b> - inadequate faculty research; insufficient time devoted to the program; faculty members do not routinely participate in conferences; faculty members are not ABIM-certified	<b>32</b>
<b>10. Performance Improvement (PI) Activities</b> – no evidence of ongoing PI activity	<b>29</b>

The newsletter planned for fall/winter will contain the most frequent citations for each subspecialty.

## **SUGGESTIONS FOR ADDRESSING CITATIONS**

In this new section of the newsletter, a frequent citation will be featured and suggestions will be made as to how avoid it.

The Review Committee noted that a number of subspecialty programs were cited last year for “inadequate multi-source evaluation” (citation category #1 above). The major reason for this citation is that programs had not documented that patients, peers, and non-physician members are used to assess a fellow’s competence with regards to interpersonal and communication skills and professionalism, and in particular, that patients have not been used. The Committee has specified in an FAQ that there must be evidence of all three types of evaluators to demonstrate compliance with the requirement for multi-source evaluation. Click [here](#) to view the subspecialties’ FAQ document.

## **PROGRAM REQUIREMENT REVISION PROCESS**

The following subspecialties’ revised program requirements were approved by the ACGME’s Committee on Requirements’ (CoR) at its February 2011 meeting: cardiovascular disease; clinical cardiac electrophysiology; interventional cardiology; pulmonary disease; pulmonary disease/critical care medicine; endocrinology; gastroenterology; transplant hepatology; hematology; medical oncology; hematology/medical oncology; infectious disease; nephrology; and rheumatology. The sleep medicine requirements were approved at the

June 2011 CoR Meeting. All requirements will become effective July 1, 2012.

Draft program requirements were developed for advanced heart failure and transplant cardiology (AHFTC), and were posted on the ACGME website for review and comment. The Review Committee will review and address all comments received at its July 2011 business meeting. The requirements will be reviewed at either the CoR's fall 2011 or spring 2012 meeting. Applications for accreditation will be made available after the requirements have been approved, in all likelihood, in the spring of 2012.

The sports medicine requirements have been modified to allow for the possibility of internal medicine-sponsored sports medicine programs. Specifically, the words "internal medicine" were inserted in the following program requirements: "the sponsoring institution must sponsor an ACGME-accredited residency program in emergency medicine, family medicine, internal medicine, pediatrics, or physical medicine and rehabilitation" (PR I.A.1), and "the sports medicine program must function as an integral part of an ACGME-accredited residency program in emergency medicine, family medicine, internal medicine, pediatrics, or physical medicine and rehabilitation" (PR I.A.1.a)). This change was approved at the June 2011 CoR meeting. Although this will allow for internal medicine-sponsored sports medicine programs, the Review Committee for Internal Medicine will not provide the accreditation review of sports medicine programs. The Review Committee for Family Medicine reviews and accredits all sports medicine programs, regardless of the ACGME-accredited core specialty with which the sports medicine program is aligned. The ACGME has applied a similar accreditation model to other subspecialties that "cross" multiple specialties (e.g., sleep medicine and hospice and palliative medicine).

#### **NEW USE FOR THE RESIDENT SURVEY**

For many years now, the ACGME has been monitoring program's responses on the Resident Survey relative to national comparison data. Programs identified as being in significant non-compliance with duty hours were warned to come into compliance or risk having their review cycles shortened. In the past, a number of programs had their review cycles shortened based on evidence of multiple years of significant non-compliance with duty hours standards. The survey contains questions in four general areas in addition to duty hours: faculty/teaching, educational content, evaluation, and resources. Last year, the ACGME recommended that Review Committees follow-up on programs identified

as being *significantly* non-compliant with duty hours and other areas of the survey. It is important to highlight that the operational definition for significant non-compliance resulted in identifying the most extreme outliers on the survey. The Review Committee reviewed the survey findings and other accreditation information of the programs with significant non-compliance rates (63 core and subspecialty programs) and decided to shorten the review cycles of six programs (two core and four subspecialty programs) because of the seriousness of the non-compliance rate. All other programs received letters informing them that they were identified as having significant compliance issues and warning them that improvement would need to be demonstrated in the 2011 administration of the Resident Survey or their review cycle would be shortened (14 core and 43 subspecialty programs received such letters).

#### **PILOT PROGRAM IMPLEMENTED BY THE DEPARTMENT OF FIELD ACTIVITIES TO RECEIVE INPUT PRIOR TO SITE VISIT**

Since the early part of the year, the ACGME Department of Field Activities (DFA) has been conducting a pilot in which the field representative asked residents/fellows prior to the program's site visit to compile a single, program-level list of up to five topics (strengths and opportunities for improvements) for further discussion during the interview. The list is requested through a note to the program director. The list is held confidential, and residents/fellows are asked to e-mail it to the field representative, or bring it to the site visit interview. The information offers the ACGME insight into residents' unique perspective on their program and the accreditation standards. Residents and fellows alike have commented favorably on the way the pilot has increased their engagement in the site visit process, including those in larger programs who do not participate in the site visit interview. The DFA will evaluate the pilot this summer. Another pilot in early evaluation entails a simple change in the sequence of the site visit process to have the resident/fellow interview completed first in the day, after a brief introductory meeting with the program director. All other interviews, review of data, and tours of facilities, if conducted, will be used to verify and clarify the information obtained during the resident/fellow interview.

#### **ACGME AWARD RECIPIENTS IN INTERNAL MEDICINE**

At the 2011 ACGME Annual Educational Conference March 3-6 in Nashville, TN, recipients of the ACGME's

*Courage to Teach*, David C. Leach, and GME Coordinator awards were honored and recognized at a formal luncheon. The *Courage to Teach Award* is named after Parker J. Palmer, PhD, a noted teacher and sociologist who wrote The Courage to Teach and other books on teaching and vocation. *Courage to Teach* awards are given annually to 10 program directors who have developed innovative teaching practices and demonstrated a commitment to educating. The Review Committee congratulates Gregory Kane, MD, of Thomas Jefferson University in Philadelphia, PA and Vijay Rajput, MD, from UMDNJ Robert Wood Johnson Medical School (Camden)/Cooper University Hospital Program in Camden, NJ, on being *Parker J. Palmer Courage to Teach Award* recipients this year. The *David C. Leach, MD, Award* is named for former ACGME Chief Executive Officer David C. Leach, MD, who retired in 2007, and recognizes residents and resident teams for improving graduate medical education. The Review Committee congratulates Andrew Miller, MD, from SUNY Health Science Center at Brooklyn in Brooklyn, NY, on receiving this award. The Review Committee also congratulates Maija Hasiba, a program coordinator at the McGaw Medical Center of Northwestern University in Chicago, IL, and Susan Scott, a program coordinator from Kessler Medical Center in Biloxi, MS, for receiving the *GME Program Coordinator Excellence Award*.

## REVIEW COMMITTEE NEWS

### New Review Committee Vice Chair

Dr. Lynne M. Kirk has been appointed as the new vice chair of the Review Committee. Dr. Kirk is the Toni and Tim P. Hartman Distinguished Teaching Professor in Internal Medicine at the University of Texas Southwestern Medical Center, as well as an associate program director in the internal medicine residency program at UT Southwestern. She is a general internist and geriatrician. Her research activities relate to medical professionalism, faculty development, clinical guidelines, and patient education. She has been on the Committee since 2008.

### Thank You and Farewell

The Review Committee would like to thank and bid farewell to Drs. Eileen Reynolds, Stuart Quan, and John Frohna. All three members have contributed significantly to the Committee and will be missed. The Committee also thanks Dr. Steffanie Campbell, who served as one of the resident members, and wishes her the best in her future endeavors.

## New Members

As of July 1, 2011, Andres Carrion, MD, Betty Lo, MD, Furman McDonald, MD, and Ilene Rosen, MD, joined the Committee. Dr. Carrion is an internal medicine resident at Jackson Memorial Hospital/University of Miami in Miami, FL. Dr. Lo is the program director of the internal medicine/pediatrics program and associate professor of clinical medicine and pediatrics at Louisiana State University in New Orleans, LA. Dr. McDonald is the program director of the internal medicine program at the College of Medicine, Mayo Clinic in Rochester, MN. Dr. Rosen is the program director of the sleep medicine program at the University of Pennsylvania in Philadelphia, PA.

## PRESENTATIONS

The presentations given at the 2011 ACGME Annual Educational Conference have been posted on the Review Committee's web page and can be accessed [here](#).

## ACGME.ORG QUICK LINKS

- [ACGME Duty Hour Standards information and resources](#)
- [Virtual Program Director Handbook](#)
- [FAQs on Master Affiliation Agreements and Program Letters of Agreement](#)
- [Case Log Tutorials](#) -- or follow these steps from the ACGME home page:
  1. Click "Data Collection Systems" from the left-hand main menu
  2. Click "Resident Case Log System" from the next drop-out menu
  3. Click "Case Log Information" from the next drop-out menu
  4. Select the top link on the next page ("New - Resident Case Log System Tutorials Web page")
- [ACGME Data Book](#)

*RRC NEWS PROVIDES TIMELY AND CURRENT REVIEW COMMITTEE AND SPECIALTY UPDATES, AS WELL AS GENERAL ACGME INFORMATION AND EXPLANATIONS OF ITS SYSTEMS, POLICIES, AND PROCEDURES. IT ALSO SERVES AS A VEHICLE FOR COMMUNICATION BETWEEN THE REVIEW COMMITTEE AND ITS CONSTITUENTS.*

*PLEASE CONTACT THE EDITOR WITH SUGGESTIONS OR COMMENTS ABOUT THIS NEWSLETTER: [MSCHWAB@ACGME.ORG](mailto:mschwab@acgme.org).*

*NEWSLETTERS ARE TYPICALLY AVAILABLE FOLLOWING A REVIEW COMMITTEE MEETING, BETWEEN ONCE AND THREE TIMES PER YEAR.*

***We'd like to know how we're doing.*** The ACGME's Department of Accreditation Committees has been working to improve newsletter content. Please e-mail the editor ([mschwab@acgme.org](mailto:mschwab@acgme.org)) with feedback on articles in recent issues -- were they useful? interesting? informative? what are we missing? what would make them better? Thank you for your input!