

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Gastroenterology (Internal Medicine)**

3
4 **Common Program Requirements are in BOLD**
5 *General Subspecialty Requirements are ITALICIZED*

6
7 Effective: July 1, 2012

8
9 **Introduction**

10
11 **Int.A. Residency is an essential dimension of the transformation of the medical**
12 **student to the independent practitioner along the continuum of medical**
13 **education. It is physically, emotionally, and intellectually demanding, and**
14 **requires longitudinally-concentrated effort on the part of the resident.**

15
16 **The specialty education of physicians to practice independently is**
17 **experiential, and necessarily occurs within the context of the health care**
18 **delivery system. Developing the skills, knowledge, and attitudes leading to**
19 **proficiency in all the domains of clinical competency requires the resident**
20 **physician to assume personal responsibility for the care of individual**
21 **patients. For the resident, the essential learning activity is interaction with**
22 **patients under the guidance and supervision of faculty members who give**
23 **value, context, and meaning to those interactions. As residents gain**
24 **experience and demonstrate growth in their ability to care for patients, they**
25 **assume roles that permit them to exercise those skills with greater**
26 **independence. This concept—graded and progressive responsibility—is**
27 **one of the core tenets of American graduate medical education.**
28 **Supervision in the setting of graduate medical education has the goals of**
29 **assuring the provision of safe and effective care to the individual patient;**
30 **assuring each resident’s development of the skills, knowledge, and**
31 **attitudes required to enter the unsupervised practice of medicine; and**
32 **establishing a foundation for continued professional growth.**

33
34 **Int.B. ~~A subspecialty education program in Gastroenterology fellowships must be~~**
35 **~~organized to provide advanced education training and experience at a level~~**
36 **~~sufficient for to allow a the fellow to acquire the competency of a specialist in the~~**
37 **~~field in the subspecialty with sufficient expertise to act as an independent~~**
38 **~~consultant.~~**

39
40 **Int.C. ~~The program must be 3 years in duration. The educational program in~~**
41 **~~gastroenterology must be 36 months in length.~~**

42
43 **I. Institutions**

44
45 **I.A. Sponsoring Institution**

46
47 **One sponsoring institution must assume ultimate responsibility for the**
48 **program, as described in the Institutional Requirements, and this**
49 **responsibility extends to fellow assignments at all participating sites.**

50
51 **The sponsoring institution and program must ensure that the program**

52 **director has sufficient protected time and financial support for his or her**
53 **educational and administrative responsibilities to the program.**

54
55 I.A.1. A gastroenterology fellowship must function as an integral part of an
56 ACGME-accredited residency ~~program~~ in internal medicine.

57
58 I.A.2. The sponsoring institution must:

59
60 I.A.2.a) establish the gastroenterology fellowship within a department of
61 internal medicine or an administrative unit whose primary mission
62 is the advancement of internal medicine subspecialty education
63 and patient care; and

64
65 I.A.2.b) ~~provide ensure~~ the program director with adequate support for the
66 administrative activities of the ~~internal medicine subspecialty~~
67 ~~program~~ fellowship.

68
69 I.A.2.b).(1) *The program director must not be required to generate*
70 *clinical or other income to provide this administrative*
71 *support.*

72
73 I.A.2.b).(2) ~~It is suggested~~ *This support should be 25-50% of the*
74 *program director's salary, or protected time, depending on*
75 *the size of the program.*

76
77 I.A.3. *The sponsoring institution and participating sites must:*

78
79 I.A.3.a) demonstrate that there is a culture of continuous quality
80 improvement in the areas of patient care, patient safety and
81 education;

82
83 I.A.3.b) demonstrate a commitment to quality patient-centered care and
84 safety, education ~~research~~ and scholarship sufficient to support
85 the fellowship program; and,

86
87 I.A.3.c) share appropriate inpatient and outpatient faculty performance
88 data with the program director.

89
90 I.A.3.d) ~~provide fellow compensation, and benefits, faculty, facilities, and~~
91 ~~resources for education, clinical care, and research required for~~
92 ~~accreditation;~~

93
94 I.A.3.e) ~~notify the Review Committee within 60 days of changes in~~
95 ~~institutional governance, affiliation, or resources that affect the~~
96 ~~educational program as outlined in the Institutional Requirements;~~
97 ~~and~~

98
99 I.A.3.f) ~~provide fellowship positions in the three-year, gastroenterology~~
100 ~~fellowship with no less than one fellow per year; and~~

101
102 **I.B. Participating Sites**

- 103
104 **I.B.1.** There must be a program letter of agreement (PLA) between the
105 program and each participating site providing a required
106 assignment. The PLA must be renewed at least every five years.
107
108 The PLA should:
109
110 **I.B.1.a)** identify the faculty who will assume both educational and
111 supervisory responsibilities for fellows;
112
113 **I.B.1.b)** specify their responsibilities for teaching, supervision, and
114 formal evaluation of fellows, as specified later in this
115 document;
116
117 **I.B.1.c)** specify the duration and content of the educational
118 experience; and
119
120 **I.B.1.d)** state the policies and procedures that will govern fellow
121 education during the assignment.
122
123 **I.B.2.** The program director must submit any additions or deletions of
124 participating sites routinely providing an educational experience,
125 required for all fellows, of one month full time equivalent (FTE) or
126 more through the Accreditation Council for Graduate Medical
127 Education (ACGME) Accreditation Data System (ADS).
128
129 **II. Program Personnel and Resources**
130
131 **II.A. Program Director**
132
133 **II.A.1.** There must be a single program director with authority and
134 accountability for the operation of the program. The sponsoring
135 institution's GMEC must approve a change in program director. After
136 approval, the program director must submit this change to the
137 ACGME via the ADS.
138
139 **II.A.2.** The program director should continue in his or her position for a
140 length of time adequate to maintain continuity of leadership and
141 program stability.
142
143 **II.A.3.** Qualifications of the program director must include:
144
145 **II.A.3.a)** requisite specialty expertise and documented educational
146 and administrative experience acceptable to the Review
147 Committee;
148
149 **II.A.3.a).(1)** The program director must have at least five years of
150 participation as an active faculty member in an ACGME-
151 accredited internal medicine residency or gastroenterology
152 fellowship.

- 153
- 154 **II.A.3.b)** **current certification in the subspecialty by the American**
- 155 **Board of Internal Medicine (ABIM), or subspecialty**
- 156 **qualifications acceptable to the Review Committee; and**
- 157
- 158 **II.A.3.b).(1)** The Review Committee only accepts current ABIM
- 159 certification in gastroenterology.
- 160
- 161 **II.A.3.c)** **current medical licensure and appropriate medical staff**
- 162 **appointment.**
- 163
- 164 **II.A.4.** **The program director must administer and maintain an educational**
- 165 **environment conducive to educating the fellows in each of the**
- 166 **ACGME competency areas. The program director must:**
- 167
- 168 **II.A.4.a)** **oversee and ensure the quality of didactic and clinical**
- 169 **education in all sites that participate in the program;**
- 170
- 171 **II.A.4.b)** **approve a local director at each participating site who is**
- 172 **accountable for fellow education;**
- 173
- 174 **II.A.4.c)** **approve the selection of program faculty as appropriate;**
- 175
- 176 **II.A.4.d)** **evaluate program faculty and approve the continued**
- 177 **participation of program faculty based on evaluation;**
- 178
- 179 **II.A.4.e)** **monitor fellow supervision at all participating sites;**
- 180
- 181 **II.A.4.f)** **prepare and submit all information required and requested by**
- 182 **the ACGME, including but not limited to the program**
- 183 **information forms and annual program fellow updates to the**
- 184 **ADS, and ensure that the information submitted is accurate**
- 185 **and complete;**
- 186
- 187 **II.A.4.g)** **provide each fellow with documented semiannual evaluation**
- 188 **of performance with feedback;**
- 189
- 190 **II.A.4.h)** **ensure compliance with grievance and due process**
- 191 **procedures, as set forth in the Institutional Requirements and**
- 192 **implemented by the sponsoring institution;**
- 193
- 194 **II.A.4.i)** **provide verification of fellowship education for all fellows,**
- 195 **including those who leave the program prior to completion;**
- 196
- 197 **II.A.4.j)** **implement policies and procedures consistent with the**
- 198 **institutional and program requirements for fellow duty hours**
- 199 **and the working environment, including moonlighting, and, to**
- 200 **that end, must:**
- 201
- 202 **II.A.4.j).(1)** **distribute these policies and procedures to the fellows**

203		and faculty;
204		
205	II.A.4.j).(2)	monitor fellow duty hours, according to sponsoring
206		institutional policies, with a frequency sufficient to
207		ensure compliance with ACGME requirements;
208		
209	II.A.4.j).(3)	adjust schedules as necessary to mitigate excessive
210		service demands and/or fatigue; and
211		
212	II.A.4.j).(4)	if applicable, monitor the demands of at-home call and
213		adjust schedules as necessary to mitigate excessive
214		service demands and/or fatigue.
215		
216	II.A.4.k)	monitor the need for and ensure the provision of back up
217		support systems when patient care responsibilities are
218		unusually difficult or prolonged;
219		
220	II.A.4.l)	comply with the sponsoring institution's written policies and
221		procedures, including those specified in Institutional
222		Requirements, for selection, evaluation and promotion of
223		fellows, disciplinary action, and supervision of fellows;
224		
225	II.A.4.m)	be familiar with and comply with ACGME and Review
226		Committee policies and procedures as outlined in the ACGME
227		Manual of Policies and Procedures;
228		
229	II.A.4.n)	obtain review and approval of the sponsoring institution's
230		GMEC/DIO before submitting to the ACGME information or
231		requests for the following:
232		
233	II.A.4.n).(1)	all applications for ACGME accreditation of new
234		programs;
235		
236	II.A.4.n).(2)	changes in fellow complement;
237		
238	II.A.4.n).(3)	major changes in program structure or length of
239		training;
240		
241	II.A.4.n).(4)	progress reports requested by the Review Committee;
242		
243	II.A.4.n).(5)	responses to all proposed adverse actions;
244		
245	II.A.4.n).(6)	requests for increases or any change to fellow duty
246		hours;
247		
248	II.A.4.n).(7)	voluntary withdrawals of ACGME-accredited
249		programs;
250		
251	II.A.4.n).(8)	requests for appeal of an adverse action;
252		

- 253 **II.A.4.n).(9)** appeal presentations to a Board of Appeal or the
254 **ACGME; and**
255
- 256 **II.A.4.n).(10)** proposals to ACGME for approval of innovative
257 educational approaches.
258
- 259 **II.A.4.o)** obtain DIO review and co-signature on all program
260 information forms, as well as any correspondence or
261 document submitted to the ACGME that addresses:
262
- 263 **II.A.4.o).(1)** program citations; and/or
264
- 265 **II.A.4.o).(2)** request for changes in the program that would have
266 significant impact, including financial, on the program
267 or institution.
268
- 269 *II.A.4.p)* *be responsible for monitoring fellow stress, including mental or*
270 *emotional conditions inhibiting performance or learning, and drug-*
271 *or alcohol-related dysfunction;*
272
- 273 **II.A.4.p).(1)** ~~*Both The program director and faculty should provide*~~
274 ~~*access to be sensitive to the need for timely provision of*~~
275 ~~*confidential counseling and psychological support services*~~
276 ~~*to fellows.*~~
277
- 278 **II.A.4.p).(2)** *Situations that demand excessive service or that*
279 *consistently produce undesirable stress on fellows must be*
280 *evaluated and modified.*
281
- 282 **II.A.4.q)** *ensure that fellows' service responsibilities are limited to patients*
283 *for whom the teaching service has diagnostic and therapeutic*
284 *responsibility.*
285
- 286 **II.A.4.r)** *dedicate an average of 20 hours per week of his or her*
287 *professional effort to the ~~internal medicine subspecialty program~~*
288 *fellowship, including with sufficient time for administration of the*
289 *~~program. and receive institutional support for that administrative~~*
290 *~~time;~~*
291
- 292 **II.A.4.s)** *participate in academic societies and in educational programs*
293 *designed to enhance his or her educational and administrative*
294 *skills;*
295
- 296 **II.A.4.t)** *have a reporting relationship with the program director of the*
297 *internal medicine residency program to ensure compliance with*
298 *~~the~~ ACGME accreditation standards; and,*
299
- 300 **II.A.4.u)** *be available ~~located~~ at the primary principal clinical site; and*
301
- 302 **II.A.4.v)** *establish a reporting relationship between him or herself and the*
303 *dependent accredited sub-subspecialty program.*

- 304
305 **II.B. Faculty**
306
- 307 **II.B.1. At each participating site, there must be a sufficient number of**
308 **faculty with documented qualifications to instruct and supervise all**
309 **fellows at that location.**
310
- 311 **The faculty must:**
312
- 313 **II.B.1.a) devote sufficient time to the educational program to fulfill**
314 **their supervisory and teaching responsibilities; and to**
315 **demonstrate a strong interest in the education of fellows; and**
316
- 317 **II.B.1.b) administer and maintain an educational environment**
318 **conducive to educating fellows in each of the ACGME**
319 **competency areas.**
320
- 321 **II.B.2. The physician faculty must have current certification in the**
322 **subspecialty by the American Board of Internal Medicine, or possess**
323 **qualifications acceptable by the Review Committee.**
324
- 325 **II.B.3. The physician faculty must possess current medical licensure and**
326 **appropriate medical staff appointment.**
327
- 328 **II.B.4. The nonphysician faculty must have appropriate qualifications in**
329 **their field and hold appropriate institutional appointments.**
330
- 331 **II.B.5. The faculty must establish and maintain an environment of inquiry**
332 **and scholarship with an active research component.**
333
- 334 **II.B.5.a) The faculty must regularly participate in organized clinical**
335 **discussions, rounds, journal clubs, and conferences.**
336
- 337 **II.B.5.b) Some members of the faculty should also demonstrate**
338 **scholarship by one or more of the following:**
339
- 340 **II.B.5.b).(1) peer-reviewed funding;**
341
- 342 **II.B.5.b).(2) publication of original research or review articles in**
343 **peer-reviewed journals or chapters in textbooks;**
344
- 345 **II.B.5.b).(3) publication or presentation of case reports or clinical**
346 **series at local, regional, or national professional and**
347 **scientific society meetings; or**
348
- 349 **II.B.5.b).(4) participation in national committees or educational**
350 **organizations.**
351
- 352 **II.B.5.c) Faculty should encourage and support fellows in scholarly**
353 **activities.**

354
355 *II.B.6. The physician faculty must meet professional standards of ethical*
356 *behavior.*
357
358 *II.B.7. Key Clinical Faculty*
359
360 *In addition to the program director, each program must have at least three*
361 *Key Clinical Faculty (KCF). KCF are attending physicians who dedicate,*
362 *on average, 10 hours per week throughout the year to the program. For*
363 *programs with more than six fellows, enrolled during the accredited*
364 *portion of the program, a ratio of KCF to fellows of at least 1: there must*
365 *be at least one KCF for every 1.5 fellows. must be maintained.*
366
367 *II.B.7.a) KCF Qualifications*
368
369 *II.B.7.a).(1) KCF must be active clinicians with ~~broad~~ knowledge of,*
370 *experience with, and commitment to gastroenterology as a*
371 *discipline.*
372
373 *II.B.7.a).(2) KCF must have current ABIM certification in*
374 *gastroenterology.*
375
376 *II.B.7.a).(3) At least one KCF should have demonstrated expertise and*
377 *primary focus in hepatology.*
378
379 *II.B.7.a).(4) At least one KCF should have demonstrated expertise in*
380 *all aspects of endoscopy, including advanced procedures.*
381
382 *II.B.7.b) Key Clinical Faculty Responsibilities*
383
384 *II.B.7.b).(1) *In addition to the responsibilities of all individual faculty**
385 *members, the KCF ~~with and~~ the program director are*
386 *responsible for the planning, implementation, monitoring*
387 *and evaluation of the fellows' clinical and research*
388 *education training.*
389
390 *II.B.7.b).(2) ~~The majority of~~ At least 50% of the KCF must demonstrate*
391 *evidence of productivity in ~~the~~ scholarship, specifically,*
392 *peer-reviewed funding; publication of original research,*
393 *review articles, editorials, or case reports in peer-reviewed*
394 *journals; or chapters in textbooks. ~~as defined in II.B.5.b.(1)~~*
395 *or (2) above*
396
397 *II.B.7.b).(3) At least one of the KCF must:*
398
399 *II.B.7.b).(3).(a) be knowledgeable in the evaluation and*
400 *assessment of the ACGME competencies; and,*
401
402 *II.B.7.b).(3).(b) spend significant time in the evaluation of fellows*
403 *including the direct observation of fellows with*
404 *patients.*

405
406 *II.B.7.b).(4)* Appointment of one KCF to be an associate program
407 director is suggested.
408
409 *II.B.8.* ~~All~~Clinical faculty members should participate in ~~prescribed~~ faculty
410 development programs designed to enhance the effectiveness of their
411 teaching.
412
413 **II.C. Other Program Personnel**
414
415 **The institution and the program must jointly ensure the availability of all**
416 **necessary professional, technical, and clerical personnel for the effective**
417 **administration the program.**
418
419 *II.C.1.* *There must be services available from other health care professionals,*
420 *including dietitians, language interpreters, nurses, occupational*
421 *therapists, physical therapists, and social workers.*
422
423 *II.C.2.* ~~There must be ensure the availability of~~ appropriate and timely
424 consultation from other specialties.
425
426 **II.D. Resources**
427
428 **The institution and the program must jointly ensure the availability of**
429 **adequate resources for fellow education, as defined in the specialty**
430 **program requirements.**
431
432 *II.D.1.* *Space and Equipment*
433
434 *There must be space and equipment for the ~~educational~~ program,*
435 *including meeting rooms, ~~classrooms,~~ examination rooms, computers,*
436 *visual and other educational aids, and work/study space.*
437
438 *II.D.2.* *Facilities*
439
440 *II.D.2.a)* Inpatient and outpatient systems must be in place to prevent
441 fellows from performing routine clerical functions, including
442 scheduling tests and appointments, and retrieving records and
443 letters.
444
445 *II.D.2.b)* The sponsoring institution must provide the broad range of
446 facilities and clinical support services required to provide
447 comprehensive care of adult patients. ~~Fellows must have clinical~~
448 experiences in efficient, effective ambulatory and inpatient care
449 settings.
450
451 *II.D.2.c)* Facilities for the intensive care of critically ill patients with
452 gastrointestinal disorders must be provided. These facilities
453 should have including a working relationship with pathology
454 services, pediatrics, oncology, radiology, and surgery.
455

- 456 II.D.2.d) *Fellows must have access to a lounge facility during assigned*
457 *duty hours.*
- 458
- 459 II.D.2.e) *When fellows are ~~assigned night duty~~ in the hospital, assigned*
460 *night duty, or called in from home, they must be provided with ~~on-~~*
461 *~~call facilities that are convenient and that afford privacy, safety,~~*
462 *~~and a restful environment with a secure space for their~~*
463 *belongings.*
- 464
- 465 II.D.3. Laboratory Services
- 466
- 467 II.D.3.a) There must be a procedure laboratory completely equipped to
468 provide modern capability in gastrointestinal procedures. This
469 equipment must include an up-to-date array of complete
470 diagnostic and therapeutic endoscopic instruments and
471 accessories, with esophageal motility instrumentation.
- 472
- 473 II.D.3.b) ~~Facilities~~ There should be a laboratory for parasitology testing-
474 ~~should be available.~~
- 475
- 476 II.D.4. ~~Other Facilities, Resources, or Support Services~~
- 477
- 478 II.D.4.a) Support services, including anesthesiology, diagnostic radiology,
479 general surgery, interventional radiology, medical imaging and
480 nuclear medicine, oncology, and pathology must be available.
- 481
- 482 II.D.5. *Medical Records*
- 483
- 484 Access to an electronic health record should be provided. In the absence
485 of an existing electronic health record, institutions must demonstrate
486 institutional commitment to its development, and progress towards its
487 implementation.
- 488
- 489 II.D.6. Patient Population
- 490
- 491 II.D.6.a) The patient population must have a variety of clinical problems
492 and stages of diseases.
- 493
- 494 II.D.6.b) *There must be patients of each ~~both~~ gender, with a broad age*
495 *range, including geriatric patients.*
- 496
- 497 II.D.6.c) *A sufficient number of patients must be available to enable ~~ensure~~*
498 *~~adequate inpatient and ambulatory experience for each fellow to~~*
499 *achieve the required educational outcomes.*
- 500
- 501 **II.E. Medical Information Access**
- 502
- 503 **Fellows must have ready access to specialty-specific and other appropriate**
504 **reference material in print or electronic format. Electronic medical literature**
505 **databases with search capabilities should be available.**
- 506

- 507 **III. Fellow Appointments**
508
- 509 **III.A. Eligibility Criteria**
510
- 511 **The program director must comply with the criteria for fellow eligibility as**
512 **specified in the Institutional Requirements.**
513
- 514 *III.A.1. ~~Prior to appointment in the fellowship program, fellows should have~~*
515 *~~completed an ACGME-accredited internal medicine education program.~~*
516
- 517 *III.A.2. ~~Fellows from non-ACGME-accredited internal medicine education~~*
518 *~~programs must have completed at least three years of internal medicine~~*
519 *~~education prior to starting the fellowship.~~*
520
- 521 *III.A.3. ~~The program director must inform non-ACGME trained applicants from~~*
522 *~~non-ACGME-accredited programs, prior to appointment, and in writing, of~~*
523 *~~the ABIM policies and procedures that may will affect the fellow's their~~*
524 *~~eligibility for ABIM certification.~~*
525
- 526 *III.A.4. ~~When averaged over any five-year period, a minimum of 75% of fellows in~~*
527 *~~each subspecialty training program must be graduates of an ACGME-~~*
528 *~~accredited internal medicine training program. ~~Non-ACGME internal~~~~*
529 *~~medicine trained fellows must have at least three years of internal~~*
530 *~~medicine training prior to starting fellowship.~~*
531
- 532 **III.B. Number of Fellows**
533
- 534 **The program director may not appoint more fellows than approved by the**
535 **Review Committee, unless otherwise stated in the specialty-specific**
536 **requirements. The program's educational resources must be adequate to**
537 **support the number of fellows appointed to the program.**
538
- 539 *III.B.1. ~~The minimum number of available fellow positions in the training program~~*
540 *~~must be at least one per year not be less than the number of accredited~~*
541 *~~training years in the program.~~*
542
- 543 **III.C. Fellow Transfers**
544
- 545 **III.C.1. Before accepting a fellow who is transferring from another program,**
546 **the program director must obtain written or electronic verification of**
547 **previous educational experiences and a summative competency-**
548 **based performance evaluation of the transferring fellow.**
549
- 550 **III.C.2. A program director must provide timely verification of fellowship**
551 **education and summative performance evaluations for fellows who**
552 **leave the program prior to completion.**
553
- 554 **III.D. Appointment of Fellows and Other Learners**
555
- 556 **The presence of other learners (including, but not limited to, residents from**

557 other specialties, subspecialty fellows, PhD students, and nurse
558 practitioners) in the program must not interfere with the appointed fellows'
559 education. The program director must report the presence of other learners
560 to the DIO and GMEC in accordance with sponsoring institution guidelines.
561

562 IV. Educational Program

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

564 IV.A.1. Overall educational goals for the program, which the program must
565 distribute to fellows and faculty annually;

566 IV.A.2. Competency-based goals and objectives for each assignment at
567 each educational level, which the program must distribute to fellows
568 and faculty annually, in either written or electronic form. These
569 should be reviewed by the fellow at the start of each rotation;

570 IV.A.3. Regularly scheduled didactic sessions; and

571 IV.A.3.a) The curriculum must include a didactic program based upon the
572 core knowledge content in the subspecialty area.

573 IV.A.3.a).(1) The program must afford each fellow an opportunity to
574 review topics covered in conferences that he or she was
575 unable to attend.

576 IV.A.3.a).(2) Fellows must participate in clinical case conferences,
577 journal clubs, research conferences, and morbidity and
578 mortality or quality improvement conferences.

579 IV.A.3.a).(3) All core conferences must have at least one faculty
580 member present, and must be scheduled as to ensure
581 peer-peer and peer-faculty interaction.

582 IV.A.3.b) Patient-based teaching must include direct interaction between
583 fellows and ~~attendings~~ faculty members, bedside teaching,
584 discussion of pathophysiology, and the use of current evidence in
585 diagnostic and therapeutic decisions. The teaching must be:

586 IV.A.3.b).(1) formally conducted on all inpatient, outpatient, and
587 consultative services; and,

588 IV.A.3.b).(2) conducted with a frequency and duration ~~sufficient to that~~
589 ensures a meaningful and continuous teaching relationship
590 between the assigned supervising faculty member(s)-
591 teaching ~~attending~~ and fellows.

592 IV.A.3.c) Fellows must receive instruction in practice management relevant
593 to gastroenterology.

594 IV.A.4. Delineation of fellow responsibilities for patient care, progressive

608 responsibility for patient management, and supervision of fellows
609 over the continuum of the program;

610
611 **IV.A.5. ACGME Competencies**

612
613 **The program must integrate the following ACGME competencies**
614 **into the curriculum:**

615
616 **IV.A.5.a) Patient care**

617
618 **Fellows must be able to provide patient care that is**
619 **compassionate, appropriate, and effective for the treatment of**
620 **health problems and the promotion of health. Fellows:**

621
622 *IV.A.5.a).(1) must demonstrate competence in the practice of health*
623 *promotion, disease prevention, diagnosis, care, and*
624 *treatment of ~~men and women~~ patients of each gender,*
625 *from adolescence to old age, during health and all stages*
626 *of illness;*

627
628 *IV.A.5.a).(2) must have formal instruction, clinical experience, and must*
629 *demonstrate competence in prevention, evaluation, and*
630 *management of the following disorders:*

631
632 *IV.A.5.a).(2).(a) acid peptic disorders of the gastrointestinal tract;*

633
634 *IV.A.5.a).(2).(b) gallstones and cholecystitis; acute and chronic*
635 *gallbladder and biliary tract diseases;*

636
637 *IV.A.5.a).(2).(c) cholestatic syndromes; acute and chronic liver*
638 *diseases;*

639
640 *IV.A.5.a).(2).(d) alcoholic liver diseases; acute and chronic*
641 *pancreatic diseases;*

642
643 *IV.A.5.a).(2).(e) diseases of the esophagus;*

644
645 *IV.A.5.a).(2).(f) disorders of nutrient assimilation;*

646
647 *IV.A.5.a).(2).(g) gastrointestinal manifestations of HIV infections;*
648 *gastrointestinal bleeding;*

649
650 *IV.A.5.a).(2).(h) gastrointestinal diseases with an immune basis;*

651
652 *IV.A.5.a).(2).(i) drug-induced hepatic injury; gastrointestinal and*
653 *hepatic neoplastic disease;*

654
655 *IV.A.5.a).(2).(j) gastrointestinal infections, including retroviral,*
656 *mycotic, and parasitic diseases;*

657
658 *IV.A.5.a).(2).(k) acute and chronic hepatitis; genetic/inherited*

659		disorders;
660		
661	IV.A.5.a).(2).(l)	chronic liver disease ; geriatric gastroenterology;
662		
663	IV.A.5.a).(2).(m)	cirrhosis and portal hypertension ; <u>GI</u>
664		<u>gastrointestinal</u> emergencies in the acutely-ill
665		patient;
666		
667	IV.A.5.a).(2).(n)	inflammatory bowel diseases;
668		
669	IV.A.5.a).(2).(o)	irritable bowel syndrome;
670		
671	IV.A.5.a).(2).(p)	motor disorders of the gastrointestinal tract;
672		
673	IV.A.5.a).(2).(q)	biliary and pancreatic diseases ; patients under
674		surgical care for gastrointestinal disorders;
675		
676	IV.A.5.a).(2).(r)	vascular disorders of the gastrointestinal tract; and,
677		
678	IV.A.5.a).(2).(s)	hepatobiliary neoplasms ; women's health issues in
679		digestive diseases;
680		
681	IV.A.5.a).(3)	must have formal instruction, clinical experience and
682		demonstrate competence in the performance of the
683		following procedures:
684		
685	IV.A.5.a).(3).(a)	biopsy of the mucosa of esophagus, stomach,
686		small bowel, and colon;
687		
688	IV.A.5.a).(3).(b)	capsule endoscopy;
689		
690	IV.A.5.a).(3).(c)	conscious sedation;
691		
692	IV.A.5.a).(3).(d)	colonoscopy with polypectomy;
693		
694	IV.A.5.a).(3).(e)	esophagogastroduodenoscopy;
695		
696	IV.A.5.a).(3).(f)	esophageal dilation;
697		
698	IV.A.5.a).(3).(g)	nonvariceal hemostasis, both upper and lower
699		including actively bleeding patients;
700		
701	IV.A.5.a).(3).(h)	variceal hemostasis including actively bleeding
702		patients;
703		
704	IV.A.5.a).(3).(i)	paracentesis;
705		
706	IV.A.5.a).(3).(j)	percutaneous endoscopic gastrostomy;
707		
708	IV.A.5.a).(3).(k)	other diagnostic and therapeutic procedures
709		utilizing enteral intubation; and,

710
711 IV.A.5.a).(3).(l) retrieval of foreign bodies from the esophagus.
712

713 **IV.A.5.b) Medical Knowledge**

714
715 **Fellows must demonstrate knowledge of established and**
716 **evolving biomedical, clinical, epidemiological and social-**
717 **behavioral sciences, as well as the application of this**
718 **knowledge to patient care. Fellows:**
719

720 IV.A.5.b).(1) *must demonstrate knowledge of the scientific method of*
721 *problem solving and evidence-based decision making;*
722 *commitment to lifelong learning, and an attitude of caring-*
723 *that is derived from humanistic and professional values*
724

725 IV.A.5.b).(2) *must ~~develop~~ demonstrate knowledge understanding of*
726 *indications, contraindications, limitations, complications,*
727 *techniques, and interpretation of results of those diagnostic*
728 *and therapeutic procedures integral to the discipline,*
729 *including the appropriate indication for and use of*
730 *screening tests/procedures;*
731

732 IV.A.5.b).(3) must demonstrate knowledge of:

733
734 IV.A.5.b).(3).(a) anatomy, physiology, pharmacology, pathology and
735 molecular biology related to the gastrointestinal
736 system, including the liver, biliary tract and
737 pancreas;

738
739 IV.A.5.b).(3).(b) ~~must demonstrate knowledge of~~ interpretation of
740 abnormal liver chemistries;

741
742 IV.A.5.b).(3).(c) ~~must demonstrate knowledge of~~ liver
743 transplantation;

744
745 IV.A.5.b).(3).(d) ~~must demonstrate knowledge of~~ nutrition;

746
747 IV.A.5.b).(3).(e) ~~must demonstrate knowledge of~~ prudent, cost-
748 effective, and judicious use of special instruments,
749 tests, and therapy in the diagnosis and
750 management of gastroenterologic disorders;

751
752 IV.A.5.b).(3).(f) ~~must demonstrate knowledge of~~ sedative
753 pharmacology; and,

754
755 IV.A.5.b).(3).(g) ~~must demonstrate knowledge of~~ surgical
756 procedures employed in relation to digestive
757 system disorders and their complications.
758

759 **IV.A.5.c) Practice-based Learning and Improvement**

760

761 Fellows must demonstrate the ability to investigate and
762 evaluate their care of patients, to appraise and assimilate
763 scientific evidence, and to continuously improve patient care
764 based on constant self-evaluation and life-long learning.
765 Fellows are expected to develop skills and habits to be able
766 to meet the following goals:

- 767
- 768 **IV.A.5.c).(1)** identify strengths, deficiencies, and limits in one's
769 knowledge and expertise;
- 770
- 771 **IV.A.5.c).(2)** set learning and improvement goals;
- 772
- 773 **IV.A.5.c).(3)** identify and perform appropriate learning activities;
- 774
- 775 **IV.A.5.c).(4)** systematically analyze practice, using quality
776 improvement methods, and implement changes with
777 the goal of practice improvement;
- 778
- 779 **IV.A.5.c).(5)** incorporate formative evaluation feedback into daily
780 practice;
- 781
- 782 **IV.A.5.c).(6)** locate, appraise, and assimilate evidence from
783 scientific studies related to their patients' health
784 problems;
- 785
- 786 **IV.A.5.c).(7)** use information technology to optimize learning;
- 787
- 788 **IV.A.5.c).(8)** participate in the education of patients, families,
789 students, fellows and other health professionals; and,
- 790
- 791 **IV.A.5.c).(9)** *obtain procedure-specific informed consent by competently*
792 *educating patients about rationale, technique, and*
793 *complications of procedures.*

794

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

796

797 **Fellows must demonstrate interpersonal and communication**
798 **skills that result in the effective exchange of information and**
799 **collaboration with patients, their families, and health**
800 **professionals. Fellows are expected to:**

- 801
- 802 **IV.A.5.d).(1)** communicate effectively with patients, families, and
803 the public, as appropriate, across a broad range of
804 socioeconomic and cultural backgrounds;
- 805
- 806 **IV.A.5.d).(2)** communicate effectively with physicians, other health
807 professionals, and health related agencies;
- 808
- 809 **IV.A.5.d).(3)** work effectively as a member or leader of a health care
810 team or other professional group;

811		
812	IV.A.5.d).(4)	act in a consultative role to other physicians and health professionals; and,
813		
814		
815	IV.A.5.d).(5)	maintain comprehensive, timely, and legible medical records, if applicable.
816		
817		
818	IV.A.5.e)	Professionalism
819		
820		Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Fellows are expected to demonstrate:
821		
822		
823		
824	IV.A.5.e).(1)	compassion, integrity, and respect for others;
825		
826	IV.A.5.e).(2)	responsiveness to patient needs that supersedes self-interest;
827		
828		
829	IV.A.5.e).(3)	respect for patient privacy and autonomy;
830		
831	IV.A.5.e).(4)	accountability to patients, society and the profession;
832		
833	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;
834		
835		
836		
837		
838	<i>IV.A.5.e).(6)</i>	<i><u>high standards of ethical behavior, including maintaining appropriate professional boundaries and relationships with other physicians and other health care team members, and avoiding conflicts of interest; and,</u></i>
839		
840		
841		
842		
843	<i>IV.A.5.e).(7)</i>	<i>a commitment to lifelong learning, and an attitude of caring derived from humanistic and professional values.</i>
844		
845		
846	IV.A.5.f)	Systems-based Practice
847		
848		Fellows 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.
849		
850		
851		
852		Fellows are expected to:
853		
854	IV.A.5.f).(1)	work effectively in various health care delivery settings and systems relevant to their clinical specialty;
855		
856		
857		
858	IV.A.5.f).(2)	coordinate patient care within the health care system relevant to their clinical specialty;
859		
860		

- 861 **IV.A.5.f).(3)** **incorporate considerations of cost awareness and**
 862 **risk-benefit analysis in patient and/or population-**
 863 **based care as appropriate;**
 864
 865 **IV.A.5.f).(4)** **advocate for quality patient care and optimal patient**
 866 **care systems;**
 867
 868 **IV.A.5.f).(5)** **work in interprofessional teams to enhance patient**
 869 **safety and improve patient care quality; and**
 870
 871 **IV.A.5.f).(6)** **participate in identifying system errors and**
 872 **implementing potential systems solutions.**
 873

874 IV.A.6. Curriculum Organization and Fellow Experiences

875
 876 IV.A.6.a) A minimum of 18 months must be devoted to clinical experience,
 877 of which the equivalent of five months should be comprised of ~~and~~
 878 ~~hepatology should comprise at least 5 months of this experience.~~

879
 880 *IV.A.6.b) Fellows must participate in training using simulation.*

881
 882 IV.A.6.c) Experience with Continuity Ambulatory Patients

883
 884 *Fellows must have continuity ambulatory clinic experience to*
 885 *develop a continuous healing relationship with patients for whom*
 886 *they provide care. This continuity experience should that exposes*
 887 *fellows them to the breadth and depth of gastroenterology.*

888
 889 IV.A.6.c).(1) ~~Overall~~-This experience should average one half-day each
 890 week.

891
 892 IV.A.6.c).(2) ~~Overall~~-This experience must include an appropriate
 893 distribution of patients of each ~~both~~ gender and a diversity
 894 of ages, which. This should be accomplished ~~by~~ through
 895 either:

896
 897 IV.A.6.c).(2).(a) a continuity clinic which provides fellows the
 898 opportunity to observe and learn the course of
 899 disease; or,

900
 901 IV.A.6.c).(2).(b) selected blocks of at least six months which
 902 address specific areas of gastrointestinal disease.

903
 904 IV.A.6.c).(3) Each fellow should, on average, be responsible for four to
 905 eight patients during each half-day session.

906
 907 IV.A.6.c).(4) The continuing patient care experience should not be
 908 interrupted by more than one month, excluding a fellow's
 909 vacation.

910
 911 IV.A.6.c).(5) ~~It is suggested that~~ Fellows should be informed of the

912		status of their continuity patients when they such patients
913		are hospitalized, <u>as clinically appropriate</u> . so the fellows
914		can make appropriate arrangements to maintain continuity
915		of care.
916		
917	IV.A.6.d)	Procedures and Technical Skills
918		
919	IV.A.6.d).(1)	<i><u>Direct faculty</u> supervision of procedures performed by each</i>
920		<i>fellow must occur until proficiency has been acquired and</i>
921		<i>documented by the program director.</i>
922		
923	IV.A.6.d).(2)	A skilled preceptor <u>Faculty members must be available to</u>
924		teach and supervise the fellows in the performance <u>and</u>
925		<u>interpretation</u> of these procedures. Procedures which
926		must be documented in each fellow's record, including
927		indications, outcomes, diagnoses, and supervisor(s).
928		
929	IV.A.6.d).(3)	Fellows must have formal instruction and clinical
930		experience in the interpretation of the following diagnostic
931		and therapeutic techniques and procedures:
932		
933	IV.A.6.d).(3).(a)	Endoscopic Retrograde
934		Cholendochopancreatography, in all its diagnostic
935		and therapeutic applications;
936		
937	IV.A.6.d).(3).(b)	enteral and parenteral alimentation;
938		
939	IV.A.6.d).(3).(c)	imaging of the digestive system, including:
940		
941	IV.A.6.d).(3).(c).(i)	computed tomography (<u>CT</u>); including CT
942		entero/colography;
943		
944	IV.A.6.d).(3).(c).(ii)	contrast radiography;
945		
946	IV.A.6.d).(3).(c).(iii)	magnetic resonance imaging;
947		
948	IV.A.6.d).(3).(c).(iv)	nuclear medicine;
949		
950	IV.A.6.d).(3).(c).(v)	percutaneous cholangiography;
951		
952	IV.A.6.d).(3).(c).(vi)	ultrasound, including endoscopic
953		ultrasound;
954		
955	IV.A.6.d).(3).(c).(vii)	vascular radiography; and,
956		
957	IV.A.6.d).(3).(c).(viii)	<u>wireless capsule endoscopy.</u>
958		
959	IV.A.6.d).(3).(d)	interpretation of enteric <u>gastrointestinal</u> and hepatic
960		biopsies; and,
961		
962	IV.A.6.d).(3).(e)	motility studies, including esophageal motility/pH

963 studies.
964
965 IV.A.6.d).(4) Fellows must have exposure to and clinical experience in
966 the performance of gastrointestinal motility studies and 24-
967 hour pH monitoring.
968

969 **IV.B. Fellows' Scholarly Activities**

970
971 **IV.B.1. The curriculum must advance fellows' knowledge of the basic**
972 **principles of research, including how research is conducted,**
973 **evaluated, explained to patients, and applied to patient care.**
974

975 **IV.B.2. Fellows should participate in scholarly activity.**

976
977 *IV.B.2.a) ~~The majority of fellows must demonstrate evidence of recent~~*
978 *~~research productivity~~ scholarship conducted during the fellowship*
979 *through one or more of the following:*
980

981 *IV.B.2.a).(1) publication of articles, book chapters, abstracts or case*
982 *reports in peer-reviewed journals;*
983

984 *IV.B.2.a).(2) publication of peer-reviewed performance improvement or*
985 *education research;*
986

987 *IV.B.2.a).(3) peer-reviewed funding; or,*
988

989 *IV.B.2.a).(4) peer-reviewed abstracts presented at regional, state or*
990 *national specialty meetings.*
991

992 **IV.B.3. The sponsoring institution and program should allocate adequate**
993 **educational resources to facilitate fellow involvement in scholarly**
994 **activities.**
995

996 **V. Evaluation**

997
998 **V.A. Fellow**
999

1000 **V.A.1. Formative Evaluation**
1001

1002 **V.A.1.a) The faculty must evaluate fellow performance in a timely**
1003 **manner during each rotation or similar educational**
1004 **assignment, and document this evaluation at completion of**
1005 **the assignment.**
1006

1007 *V.A.1.a).(1) ~~The faculty must discuss this evaluation with the~~ each*
1008 *fellow at the completion of the ~~each~~ assignment.*
1009

1010 *V.A.1.a).(2) Assessment of procedural competence should include a*
1011 *formal evaluation process and not be based solely on a*
1012 *minimum number of procedures performed.*

1013		
1014	V.A.1.b)	The program must:
1015		
1016	V.A.1.b).(1)	provide objective assessments of competence in
1017		patient care, medical knowledge, practice-based
1018		learning and improvement, interpersonal and
1019		communication skills, professionalism, and systems-
1020		based practice;
1021		
1022	V.A.1.b).(1).(a)	<u>Patient care</u>
1023		
1024		<u>The program must assess the fellow in data</u>
1025		<u>gathering, clinical reasoning, patient management</u>
1026		<u>and procedures in both the inpatient and outpatient</u>
1027		<u>setting. This assessment must involve direct</u>
1028		<u>observation of fellow-patient encounters.</u>
1029		
1030	V.A.1.b).(1).(a).(i)	<u>Each program must define a standard</u>
1031		<u>criteria for proficiency competence for all</u>
1032		<u>required and elective procedures.</u>
1033		
1034	V.A.1.b).(1).(a).(ii)	<u>The record of evaluation must include the</u>
1035		<u>fellow's logbook or an equivalent method to</u>
1036		<u>demonstrate that each fellow has achieved</u>
1037		<u>competence in the performance of required</u>
1038		<u>procedures.</u>
1039		
1040	V.A.1.b).(1).(b)	<u>Medical Knowledge</u>
1041		
1042		<u>The program must use an objective formative</u>
1043		<u>assessment method. The same formative</u>
1044		<u>assessment method must be administered at least</u>
1045		<u>twice during the program.</u>
1046		
1047	V.A.1.b).(1).(c)	<u>Practice-based Learning and Improvement</u>
1048		
1049		<u>The program must use performance data to assess</u>
1050		<u>the fellow in:</u>
1051		
1052	V.A.1.b).(1).(c).(i)	<u>application of evidence to patient care;</u>
1053		
1054	V.A.1.b).(1).(c).(ii)	<u>practice improvement;</u>
1055		
1056	V.A.1.b).(1).(c).(iii)	<u>teaching skills involving peers and patients;</u>
1057		<u>and,</u>
1058		
1059	V.A.1.b).(1).(c).(iv)	<u>scholarship.</u>
1060		
1061	V.A.1.b).(1).(d)	<u>Interpersonal and Communication Skills</u>
1062		
1063		<u>The program must use both direct observation and</u>

1064		<u>multi-source evaluation, including patients, peers</u>
1065		<u>and non-physician team members, to assess fellow</u>
1066		<u>performance in:</u>
1067		
1068	V.A. 1.b).(1).(d).(i)	<u>communication with patient and family;</u>
1069		
1070	V.A. 1.b).(1).(d).(ii)	<u>teamwork;</u>
1071		
1072	V.A. 1.b).(1).(d).(iii)	<u>communication with peers, including</u>
1073		<u>transitions in care; and,</u>
1074		
1075	V.A. 1.b).(1).(d).(iv)	<u>record keeping.</u>
1076		
1077	V.A. 1.b).(1).(e)	<u>Professionalism</u>
1078		
1079		<u>The program must use multi-source evaluation,</u>
1080		<u>including patients, peers, and non-physician team</u>
1081		<u>members, to assess each fellow's:</u>
1082		
1083	V.A. 1.b).(1).(e).(i)	<u>honesty and integrity;</u>
1084		
1085	V.A. 1.b).(1).(e).(ii)	<u>ability to meet professional responsibilities;</u>
1086		
1087	V.A. 1.b).(1).(e).(iii)	<u>ability to maintain appropriate professional</u>
1088		<u>relationships with patients and colleagues;</u>
1089		<u>and,</u>
1090		
1091	V.A. 1.b).(1).(e).(iv)	<u>commitment to self-improvement.</u>
1092		
1093	V.A. 1.b).(1).(f)	<u>Systems-based Practice</u>
1094		
1095		<u>The program must use multi-source evaluation,</u>
1096		<u>including peers, and non-physician team members,</u>
1097		<u>to assess each fellow's:</u>
1098		
1099	V.A. 1.b).(1).(f).(i)	<u>ability to provide care coordination,</u>
1100		<u>including transition of care;</u>
1101		
1102	V.A. 1.b).(1).(f).(ii)	<u>ability to work in interdisciplinary teams;</u>
1103		
1104	V.A. 1.b).(1).(f).(iii)	<u>advocacy for quality of care; and,</u>
1105		
1106	V.A. 1.b).(1).(f).(iv)	<u>ability to identify system problems and</u>
1107		<u>participate in improvement activities.</u>
1108		
1109	V.A.1.b).(2)	use multiple evaluators (e.g., faculty, peers, patients,
1110		self, and other professional staff);
1111		
1112	V.A.1.b).(3)	document progressive fellow performance
1113		improvement appropriate to educational level; and
1114		

- 1115 **V.A.1.b).(4)** provide each fellow with documented semiannual
 1116 evaluation of performance with feedback.
 1117
- 1118 *V.A.1.b).(4).(a) Fellows' performance in continuity clinic must be*
 1119 *reviewed with them verbally and in writing at least*
 1120 *semiannually.*
 1121
- 1122 **V.A.1.c)** The evaluations of fellow performance must be accessible for
 1123 review by the fellow, in accordance with institutional policy.
 1124
- 1125 **V.A.2.** Summative Evaluation
 1126
 1127 The program director must provide a summative evaluation for each
 1128 fellow upon completion of the program. This evaluation must
 1129 become part of the fellow's permanent record maintained by the
 1130 institution, and must be accessible for review by the fellow in
 1131 accordance with institutional policy. This evaluation must:
 1132
- 1133 **V.A.2.a)** document the fellow's performance during the final period of
 1134 education; and
 1135
- 1136 **V.A.2.b)** verify that the fellow has demonstrated sufficient competence
 1137 to enter practice without direct supervision.
 1138
- 1139 **V.B.** Faculty Evaluation
 1140
- 1141 **V.B.1.** At least annually, the program must evaluate faculty performance as
 1142 it relates to the educational program.
 1143
- 1144 **V.B.2.** These evaluations should include a review of faculty's clinical
 1145 teaching abilities, commitment to the educational program, clinical
 1146 knowledge, professionalism, and scholarly activities.
 1147
- 1148 **V.B.3.** This evaluation must include at least annual written confidential
 1149 evaluations by fellows.
 1150
- 1151 *V.B.3.a) ~~In addition,~~ Fellows must have the opportunity to provide*
 1152 *confidential written evaluations of each supervising faculty*
 1153 *member at the end of a rotation.*
 1154
- 1155 *V.B.3.b) ~~The program director must be reviewed~~ These evaluations must*
 1156 *be reviewed with each ~~attending~~ faculty member annually.*
 1157
- 1158 **V.C.** Program Evaluation and Improvement
 1159
- 1160 **V.C.1.** The program must document formal, systematic evaluation of the
 1161 curriculum at least annually. The program must monitor and track
 1162 each of the following areas:
 1163
- 1164 **V.C.1.a)** fellow performance;

1165		
1166	V.C.1.b)	faculty development;
1167		
1168	V.C.1.c)	graduate performance, including performance of program
1169		graduates on the certification examination; and
1170		
1171	V.C.1.c).(1)	<i>At least 80% of <u>program's graduating fellows from those</u></i>
1172		<i><u>eligible to take an ABIM subspecialty certifying</u></i>
1173		<i><u>examination upon completion of their training for the most</u></i>
1174		<i><u>recently defined five year period who are eligible should</u></i>
1175		<i><u>must have taken an <u>the</u> ABIM subspecialty certifying</u></i>
1176		<i><u>examination. (Note: Five-year rolling pass rate for first time</u></i>
1177		<i><u>takers of the ABIM certifying examination will be examined</u></i>
1178		<i><u>at each program review).</u></i>
1179		
1180	V.C.1.c).(2)	<i><u>At least 80% of a program's graduates taking the ABIM</u></i>
1181		<i><u>certifying examination for the first time during the most</u></i>
1182		<i><u>recently defined five year period should pass.</u></i>
1183		
1184	V.C.1.d)	program quality. Specifically:
1185		
1186	V.C.1.d).(1)	Fellows and faculty must have the opportunity to
1187		evaluate the program confidentially and in writing at
1188		least annually.
1189		
1190	V.C.1.d).(2)	The program must use the results of fellows'
1191		assessments of the program together with other
1192		program evaluation results to improve the program.
1193		
1194	V.C.1.d).(3)	<i><u>At least 80% of the entering fellows should have</u></i>
1195		<i><u>completed the program when averaged over a five-year</u></i>
1196		<i><u>period.</u></i>
1197		
1198	V.C.2.	If deficiencies are found, the program should prepare a written plan
1199		of action to document initiatives to improve performance in the
1200		areas listed in section V.C.1. The action plan should be reviewed
1201		and approved by the teaching faculty and documented in meeting
1202		minutes.
1203		
1204	V.C.3.	<i><u>The program must organize Representative program personnel, at a</u></i>
1205		<i><u>minimum to include the program director, representative faculty, and one</u></i>
1206		<i><u>fellow, to must review program goals and objectives, and the</u></i>
1207		<i><u>effectiveness with which they are achieved.</u></i>
1208		
1209	VI.	Fellow Duty Hours in the Learning and Working Environment
1210		
1211	VI.A.	Professionalism, Personal Responsibility, and Patient Safety
1212		
1213	VI.A.1.	Programs and sponsoring institutions must educate fellows and
1214		faculty members concerning the professional responsibilities of

- 1215 physicians to appear for duty appropriately rested and fit to provide
 1216 the services required by their patients.
 1217
- 1218 **VI.A.2.** The program must be committed to and responsible for promoting
 1219 patient safety and fellow well-being in a supportive educational
 1220 environment.
 1221
- 1222 **VI.A.3.** The program director must ensure that fellows are integrated and
 1223 actively participate in interdisciplinary clinical quality improvement
 1224 and patient safety programs.
 1225
- 1226 **VI.A.4.** The learning objectives of the program must:
 1227
- 1228 **VI.A.4.a)** be accomplished through an appropriate blend of supervised
 1229 patient care responsibilities, clinical teaching, and didactic
 1230 educational events; and,
 1231
- 1232 **VI.A.4.b)** not be compromised by excessive reliance on fellows to fulfill
 1233 non-physician service obligations.
 1234
- 1235 ~~VI.A.4.b).(1) ————— *Fellows' service responsibilities must be limited to patients*~~
 1236 ~~*for whom the teaching service has diagnostic and*~~
 1237 ~~*therapeutic responsibility.*~~
 1238
- 1239 **VI.A.5.** The program director and institution must ensure a culture of
 1240 professionalism that supports patient safety and personal
 1241 responsibility. Fellows and faculty members must demonstrate an
 1242 understanding and acceptance of their personal role in the
 1243 following:
 1244
- 1245 **VI.A.5.a)** assurance of the safety and welfare of patients entrusted to
 1246 their care;
 1247
- 1248 **VI.A.5.b)** provision of patient- and family-centered care;
 1249
- 1250 **VI.A.5.c)** assurance of their fitness for duty;
 1251
- 1252 **VI.A.5.d)** management of their time before, during, and after clinical
 1253 assignments;
 1254
- 1255 **VI.A.5.e)** recognition of impairment, including illness and fatigue, in
 1256 themselves and in their peers;
 1257
- 1258 **VI.A.5.f)** attention to lifelong learning;
 1259
- 1260 **VI.A.5.g)** the monitoring of their patient care performance improvement
 1261 indicators; and,
 1262
- 1263 **VI.A.5.h)** honest and accurate reporting of duty hours, patient
 1264 outcomes, and clinical experience data.

1265		
1266	VI.A.6.	All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize 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.
1267		
1268		
1269		
1270		
1271		
1272	VI.B.	Transitions of Care
1273		
1274	VI.B.1.	Programs must design clinical assignments to minimize the number of transitions in patient care.
1275		
1276		
1277	VI.B.2.	Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
1278		
1279		
1280		
1281	VI.B.3.	Programs must ensure that fellows are competent in communicating with team members in the hand-over process.
1282		
1283		
1284	VI.B.4.	The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient's care.
1285		
1286		
1287		
1288	VI.C.	Alertness Management/Fatigue Mitigation
1289		
1290	VI.C.1.	The program must:
1291		
1292	VI.C.1.a)	educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;
1293		
1294		
1295	VI.C.1.b)	educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,
1296		
1297		
1298	VI.C.1.c)	adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.
1299		
1300		
1301		
1302	VI.C.2.	Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties.
1303		
1304		
1305		
1306	VI.C.3.	The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home.
1307		
1308		
1309		
1310	VI.D.	Supervision of Fellows
1311		
1312	VI.D.1.	In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each
1313		
1314		

1315 Review Committee) who is ultimately responsible for that patient's
1316 care.
1317

1318 **VI.D.1.a)** This information should be available to fellows, faculty
1319 members, and patients.
1320

1321 **VI.D.1.b)** Fellows and faculty members should inform patients of their
1322 respective roles in each patient's care.
1323

1324 **VI.D.2.** The program must demonstrate that the appropriate level of
1325 supervision is in place for all fellows who care for patients.
1326

1327 Supervision may be exercised through a variety of methods. Some
1328 activities require the physical presence of the supervising faculty
1329 member. For many aspects of patient care, the supervising
1330 physician may be a more advanced resident or fellow. Other
1331 portions of care provided by the fellow can be adequately
1332 supervised by the immediate availability of the supervising faculty
1333 member or resident physician, either in the institution, or by means
1334 of telephonic and/or electronic modalities. In some circumstances,
1335 supervision may include post-hoc review of fellow-delivered care
1336 with feedback as to the appropriateness of that care.
1337

1338 **VI.D.3.** Levels of Supervision
1339

1340 To ensure oversight of fellow supervision and graded authority and
1341 responsibility, the program must use the following classification of
1342 supervision:
1343

1344 **VI.D.3.a)** Direct Supervision – the supervising physician is physically
1345 present with the fellow and patient.
1346

1347 **VI.D.3.b)** Indirect Supervision:
1348

1349 **VI.D.3.b).(1)** with direct supervision immediately available – the
1350 supervising physician is physically within the hospital
1351 or other site of patient care, and is immediately
1352 available to provide Direct Supervision.
1353

1354 **VI.D.3.b).(2)** with direct supervision available – the supervising
1355 physician is not physically present within the hospital
1356 or other site of patient care, but is immediately
1357 available by means of telephonic and/or electronic
1358 modalities, and is available to provide Direct
1359 Supervision.
1360

1361 **VI.D.3.c)** Oversight – the supervising physician is available to provide
1362 review of procedures/encounters with feedback provided
1363 after care is delivered.
1364

- 1365 **VI.D.4.** **The privilege of progressive authority and responsibility, conditional**
1366 **independence, and a supervisory role in patient care delegated to**
1367 **each fellow must be assigned by the program director and faculty**
1368 **members.**
1369
- 1370 **VI.D.4.a)** **The program director must evaluate each fellow’s abilities**
1371 **based on specific criteria. When available, evaluation should**
1372 **be guided by specific national standards-based criteria.**
1373
- 1374 **VI.D.4.b)** **Faculty members functioning as supervising physicians**
1375 **should delegate portions of care to fellows, based on the**
1376 **needs of the patient and the skills of the fellows.**
1377
- 1378 **VI.D.4.c)** **Senior residents or fellows should serve in a supervisory role**
1379 **of junior residents in recognition of their progress toward**
1380 **independence, based on the needs of each patient and the**
1381 **skills of the individual resident or fellow.**
1382
- 1383 **VI.D.5.** **Programs must set guidelines for circumstances and events in**
1384 **which fellows must communicate with appropriate supervising**
1385 **faculty members, such as the transfer of a patient to an intensive**
1386 **care unit, or end-of-life decisions.**
1387
- 1388 **VI.D.5.a)** **Each fellow must know the limits of his/her scope of**
1389 **authority, and the circumstances under which he/she is**
1390 **permitted to act with conditional independence.**
1391
- 1392 **VI.D.5.a).(1)** **In particular, PGY-1 residents should be supervised**
1393 **either directly or indirectly with direct supervision**
1394 **immediately available.**
1395
- 1396 **VI.D.6.** **Faculty supervision assignments should be of sufficient duration to**
1397 **assess the knowledge and skills of each fellow and delegate to**
1398 **him/her the appropriate level of patient care authority and**
1399 **responsibility.**
1400
- 1401 **VI.E.** **Clinical Responsibilities**
1402
1403 **The clinical responsibilities for each fellow must be based on PGY-level,**
1404 **patient safety, fellow education, severity and complexity of patient**
1405 **illness/condition and available support services.**
1406
- 1407 **VI.F.** **Teamwork**
1408
1409 **Fellows must care for patients in an environment that maximizes effective**
1410 **communication. This must include the opportunity to work as a member of**
1411 **effective interprofessional teams that are appropriate to the delivery of care**
1412 **in the specialty.**
1413
- 1414 **VI.G.** **Fellow Duty Hours**

1415		
1416	VI.G.1.	Maximum Hours of Work per Week
1417		
1418		Duty hours must be limited to 80 hours per week, averaged over a
1419		four-week period, inclusive of all in-house call activities and all
1420		moonlighting.
1421		
1422	VI.G.1.a)	Duty Hour Exceptions
1423		
1424		A Review Committee may grant exceptions for up to 10% or a
1425		maximum of 88 hours to individual programs based on a
1426		sound educational rationale.
1427		
1428		<i>The Review Committee for Internal Medicine will not consider</i>
1429		<i>requests for exceptions to the 80-hour limit to the fellows' work</i>
1430		<i>week.</i>
1431		
1432	VI.G.1.a).(1)	In preparing a request for an exception the program
1433		director must follow the duty hour exception policy
1434		from the ACGME Manual on Policies and Procedures.
1435		
1436	VI.G.1.a).(2)	Prior to submitting the request to the Review
1437		Committee, the program director must obtain approval
1438		of the institution's GMEC and DIO.
1439		
1440	VI.G.2.	Moonlighting
1441		
1442	VI.G.2.a)	Moonlighting must not interfere with the ability of the fellow
1443		to achieve the goals and objectives of the educational
1444		program.
1445		
1446	VI.G.2.b)	Time spent by fellows in Internal and External Moonlighting
1447		(as defined in the ACGME Glossary of Terms) must be
1448		counted towards the 80-hour Maximum Weekly Hour Limit.
1449		
1450	VI.G.2.c)	PGY-1 residents are not permitted to moonlight.
1451		
1452	VI.G.3.	Mandatory Time Free of Duty
1453		
1454		Fellows must be scheduled for a minimum of one day free of duty
1455		every week (when averaged over four weeks). At-home call cannot
1456		be assigned on these free days.
1457		
1458	VI.G.4.	Maximum Duty Period Length
1459		
1460	VI.G.4.a)	Duty periods of PGY-1 residents must not exceed 16 hours in
1461		duration.
1462		
1463	VI.G.4.b)	Duty periods of PGY-2 residents and above may be
1464		scheduled to a maximum of 24 hours of continuous duty in

1465 the hospital. Programs must encourage fellows to use
1466 alertness management strategies in the context of patient
1467 care responsibilities. Strategic napping, especially after 16
1468 hours of continuous duty and between the hours of 10:00
1469 p.m. and 8:00 a.m., is strongly suggested.

1470

1471 **VI.G.4.b).(1)** It is essential for patient safety and fellow education
1472 that effective transitions in care occur. Fellows may be
1473 allowed to remain on-site in order to accomplish these
1474 tasks; however, this period of time must be no longer
1475 than an additional four hours.

1476

1477 **VI.G.4.b).(2)** Fellows must not be assigned additional clinical
1478 responsibilities after 24 hours of continuous in-house
1479 duty.

1480

1481 **VI.G.4.b).(3)** In unusual circumstances, fellows, on their own
1482 initiative, may remain beyond their scheduled period
1483 of duty to continue to provide care to a single patient.
1484 Justifications for such extensions of duty are limited
1485 to reasons of required continuity for a severely ill or
1486 unstable patient, academic importance of the events
1487 transpiring, or humanistic attention to the needs of a
1488 patient or family.

1489

1490 **VI.G.4.b).(3).(a)** Under those circumstances, the fellow must:

1491

1492 **VI.G.4.b).(3).(a).(i)** appropriately hand over the care of all
1493 other patients to the team responsible
1494 for their continuing care; and,
1495

1496 **VI.G.4.b).(3).(a).(ii)** document the reasons for remaining to
1497 care for the patient in question and
1498 submit that documentation in every
1499 circumstance to the program director.

1500

1501 **VI.G.4.b).(3).(b)** The program director must review each
1502 submission of additional service, and track
1503 both individual fellow and program-wide
1504 episodes of additional duty.

1505

1506 **VI.G.5. Minimum Time Off between Scheduled Duty Periods**

1507

1508 **VI.G.5.a)** PGY-1 residents should have 10 hours, and must have eight
1509 hours, free of duty between scheduled duty periods.

1510

1511 **VI.G.5.b)** Intermediate-level residents have 10 hours free of duty, and
1512 must have eight hours between scheduled duty periods. They
1513 must have at least 14 hours free of duty after 24 hours of in-
1514 house duty.

1515		
1516		<u>Internal medicine subspecialty fellows are considered to be in the</u>
1517		<u>final years of education.</u>
1518		
1519	VI.G.5.c)	Residents in the final years of education be prepared to enter
1520		the unsupervised practice of medicine and care for patients
1521		over irregular or extended periods.
1522		
1523		<u>Internal medicine subspecialty fellows are considered to be in the</u>
1524		<u>final years of education.</u>
1525		
1526	VI.G.5.c).(1)	This preparation must occur within the context of the
1527		80-hour, maximum duty period length, and one-day-
1528		off-in-seven standards. While it is desirable that
1529		fellows in their final years of education have eight
1530		hours free of duty between scheduled duty periods,
1531		there may be circumstances when these fellows must
1532		stay on duty to care for their patients or return to the
1533		hospital with fewer than eight hours free of duty.
1534		
1535	VI.G.5.c).(1).(a)	Circumstances of return-to-hospital activities
1536		with fewer than eight hours away from the
1537		hospital by fellows in their final years of
1538		education must be monitored by the program
1539		director.
1540		
1541	VI.G.5.c).(1).(b)	<u>In unusual circumstances, fellows may remain</u>
1542		<u>beyond their scheduled period of duty or return</u>
1543		<u>after their scheduled period of duty to provide care</u>
1544		<u>to a single patient. Justifications for such</u>
1545		<u>extensions of duty are limited to reasons of</u>
1546		<u>required continuity of care for a severely ill or</u>
1547		<u>unstable patient, academic importance of the</u>
1548		<u>events transpiring, or humanistic attention to the</u>
1549		<u>needs of the patient or family. Such episodes</u>
1550		<u>should be rare, must be of the fellows' own</u>
1551		<u>initiative, and need not initiate a new 'off-duty</u>
1552		<u>period' nor require a change in the scheduled 'off-</u>
1553		<u>duty period.'</u>
1554		
1555	VI.G.5.c).(1).(c)	<u>Under such circumstances, the fellow must</u>
1556		<u>appropriately hand over care of all other patients to</u>
1557		<u>the team responsible for their continuing care, and</u>
1558		<u>document the reasons for remaining or returning to</u>
1559		<u>care for the patient in question and submit that</u>
1560		<u>documentation to the program director.</u>
1561		
1562	VI.G.5.c).(1).(d)	<u>The program director must review each submission</u>
1563		<u>of additional service and track both individual</u>
1564		<u>fellows' and program-wide episodes of additional</u>
1565		<u>duty.</u>

1566
1567 **VI.G.6. Maximum Frequency of In-House Night Float**
1568
1569 **Fellows must not be scheduled for more than six consecutive nights**
1570 **of night float.**
1571
1572 **VI.G.7. Maximum In-House On-Call Frequency**
1573
1574 **PGY-2 residents and above must be scheduled for in-house call no**
1575 **more frequently than every-third-night (when averaged over a four-**
1576 **week period).**
1577
1578 *VI.G.7.a) ~~Internal Medicine residency programs are~~ fellowships must not*
1579 *~~allowed to average in-house call over a four-week period.~~*
1580
1581 **VI.G.8. At-Home Call**
1582
1583 **VI.G.8.a) Time spent in the hospital by fellows on at-home call must**
1584 **count towards the 80-hour maximum weekly hour limit. The**
1585 **frequency of at-home call is not subject to the every-third-**
1586 **night limitation, but must satisfy the requirement for one-day-**
1587 **in-seven free of duty, when averaged over four weeks.**
1588
1589 **VI.G.8.a).(1) At-home call must not be so frequent or taxing as to**
1590 **preclude rest or reasonable personal time for each**
1591 **fellow.**
1592
1593 **VI.G.8.b) Fellows are permitted to return to the hospital while on at-**
1594 **home call to care for new or established patients. Each**
1595 **episode of this type of care, while it must be included in the**
1596 **80-hour weekly maximum, will not initiate a new “off-duty**
1597 **period”.**
1598
1599 **VII. Innovative Projects**
1600
1601 **Requests for innovative projects that may deviate from the institutional, common**
1602 **and/or specialty specific program requirements must be approved in advance by**
1603 **the Review Committee. In preparing requests, the program director must follow**
1604 **Procedures for Approving Proposals for Innovative Projects located in the ACGME**
1605 **Manual on Policies and Procedures. Once a Review Committee approves a**
1606 **project, the sponsoring institution and program are jointly responsible for the**
1607 **quality of education offered to fellows for the duration of such a project.**
1608
1609 *******
1610
1611 **ACGME Approved: February 5, 2011 Effective: July 1, 2012**