

1 **ACGME Program Requirements for Graduate Medical Education**  
2 **in Hematology (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. ~~Subspecialty programs must~~ Hematology fellowships provide advanced training**  
35 **~~education~~ to allow the a fellow to acquire competency in the subspecialty with**  
36 **sufficient expertise to act as an independent consultant.**

37  
38 **Int.C. ~~An~~ The educational program accredited fellowship in hematology must provide**  
39 **be 24 months of supervised graduate medical education in length.**

40  
41 **I. Institutions**

42  
43 **I.A. Sponsoring Institution**

44  
45 **One sponsoring institution must assume ultimate responsibility for the**  
46 **program, as described in the Institutional Requirements, and this**  
47 **responsibility extends to fellow assignments at all participating sites.**

48  
49 **The sponsoring institution and program must ensure that the program**  
50 **director has sufficient protected time and financial support for his or her**  
51 **educational and administrative responsibilities to the program.**

- 52
- 53 I.A.1. A hematology fellowship must function as an integral part of an ACGME-  
54 accredited residency program in internal medicine.
- 55
- 56 I.A.2. *The sponsoring institution must:*
- 57
- 58 I.A.2.a) establish the hematology fellowship within a department of internal  
59 medicine or an administrative unit whose primary mission is the  
60 advancement of internal medicine subspecialty education and  
61 patient care; and
- 62
- 63 I.A.2.b) ~~provide ensure~~ *the program director with adequate support for the*  
64 *administrative activities of the ~~internal medicine subspecialty~~*  
65 *~~program-fellowship.~~*
- 66
- 67 I.A.2.b).(1) *The program director must not be required to generate*  
68 *clinical or other income to provide this administrative*  
69 *support.*
- 70
- 71 I.A.2.b).(2) ~~It is suggested~~ *This support should be 25-50% of the*  
72 *program director's salary, or protected time depending on*  
73 *the size of the program.*
- 74
- 75 I.A.3. *The sponsoring institution and participating sites must:*
- 76
- 77 I.A.3.a) *demonstrate that there is a culture of continuous quality*  
78 *improvement in the areas of patient care, patient safety, and*  
79 *education;*
- 80
- 81 I.A.3.b) *demonstrate a commitment to quality patient-centered care and*  
82 *safety, education ~~research~~ and scholarship sufficient to support*  
83 *the fellowship ~~program;~~ and*
- 84
- 85 I.A.3.c) *share appropriate inpatient and outpatient faculty performance*  
86 *data with the program director.*
- 87
- 88 I.A.3.d) ~~*provide fellow compensation, and benefits, faculty, facilities, and*~~  
89 ~~*resources for education, clinical care, and research required for*~~  
90 ~~*accreditation;*~~
- 91
- 92 I.A.3.e) ~~*notify the Review Committee within 60-30 days of changes in*~~  
93 ~~*institutional governance, affiliation, or resources that affect the*~~  
94 ~~*educational program as outlined in the Institutional Requirements;*~~  
95 ~~*and*~~
- 96
- 97 I.A.3.f) ~~*provide fellowship positions in each training program that do not*~~  
98 ~~*number the number of accredited training in the program;*~~
- 99
- 100 **I.B. Participating Sites**
- 101
- 102 **I.B.1. There must be a program letter of agreement (PLA) between the**

103 program and each participating site providing a required  
104 assignment. The PLA must be renewed at least every five years.

105  
106 The PLA should:

107  
108 **I.B.1.a)** identify the faculty who will assume both educational and  
109 supervisory responsibilities for fellows;

110  
111 **I.B.1.b)** specify their responsibilities for teaching, supervision, and  
112 formal evaluation of fellows, as specified later in this  
113 document;

114  
115 **I.B.1.c)** specify the duration and content of the educational  
116 experience; and,

117  
118 **I.B.1.d)** state the policies and procedures that will govern fellow  
119 education during the assignment.

120  
121 **I.B.2.** The program director must submit any additions or deletions of  
122 participating sites routinely providing an educational experience,  
123 required for all fellows, of one month full time equivalent (FTE) or  
124 more through the Accreditation Council for Graduate Medical  
125 Education (ACGME) Accreditation Data System (ADS).  
126

## 127 **II. Program Personnel and Resources**

### 128 129 **II.A. Program Director**

130  
131 **II.A.1.** There must be a single program director with authority and  
132 accountability for the operation of the program. The sponsoring  
133 institution's GMCC must approve a change in program director. After  
134 approval, the program director must submit this change to the  
135 ACGME via the ADS.  
136

137 **II.A.2.** The program director should continue in his or her position for a  
138 length of time adequate to maintain continuity of leadership and  
139 program stability.  
140

141 **II.A.3.** Qualifications of the program director must include:

142  
143 **II.A.3.a)** requisite specialty expertise and documented educational  
144 and administrative experience acceptable to the Review  
145 Committee;  
146

147 **II.A.3.a).(1)** The program director must have at least five years of  
148 participation as an active faculty member in an ACGME-  
149 accredited internal medicine residency or hematology  
150 fellowship.  
151

152 **II.A.3.b)** current certification in the subspecialty by the American

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

203	<b>II.A.4.j).(2)</b>	<b>monitor fellow duty hours, according to sponsoring</b>
204		<b>institutional policies, with a frequency sufficient to</b>
205		<b>ensure compliance with ACGME requirements;</b>
206		
207	<b>II.A.4.j).(3)</b>	<b>adjust schedules as necessary to mitigate excessive</b>
208		<b>service demands and/or fatigue; and,</b>
209		
210	<b>II.A.4.j).(4)</b>	<b>if applicable, monitor the demands of at-home call and</b>
211		<b>adjust schedules as necessary to mitigate excessive</b>
212		<b>service demands and/or fatigue.</b>
213		
214	<b>II.A.4.k)</b>	<b>monitor the need for and ensure the provision of back up</b>
215		<b>support systems when patient care responsibilities are</b>
216		<b>unusually difficult or prolonged;</b>
217		
218	<b>II.A.4.l)</b>	<b>comply with the sponsoring institution's written policies and</b>
219		<b>procedures, including those specified in Institutional</b>
220		<b>Requirements, for selection, evaluation and promotion of</b>
221		<b>fellows, disciplinary action, and supervision of fellows;</b>
222		
223	<b>II.A.4.m)</b>	<b>be familiar with and comply with ACGME and Review</b>
224		<b>Committee policies and procedures as outlined in the ACGME</b>
225		<b>Manual of Policies and Procedures;</b>
226		
227	<b>II.A.4.n)</b>	<b>obtain review and approval of the sponsoring institution's</b>
228		<b>GMEC/DIO before submitting to the ACGME information or</b>
229		<b>requests for the following:</b>
230		
231	<b>II.A.4.n).(1)</b>	<b>all applications for ACGME accreditation of new</b>
232		<b>programs;</b>
233		
234	<b>II.A.4.n).(2)</b>	<b>changes in fellow complement;</b>
235		
236	<b>II.A.4.n).(3)</b>	<b>major changes in program structure or length of</b>
237		<b>training;</b>
238		
239	<b>II.A.4.n).(4)</b>	<b>progress reports requested by the Review Committee;</b>
240		
241	<b>II.A.4.n).(5)</b>	<b>responses to all proposed adverse actions;</b>
242		
243	<b>II.A.4.n).(6)</b>	<b>requests for increases or any change to fellow duty</b>
244		<b>hours;</b>
245		
246	<b>II.A.4.n).(7)</b>	<b>voluntary withdrawals of ACGME-accredited</b>
247		<b>programs;</b>
248		
249	<b>II.A.4.n).(8)</b>	<b>requests for appeal of an adverse action;</b>
250		
251	<b>II.A.4.n).(9)</b>	<b>appeal presentations to a Board of Appeal or the</b>
252		<b>ACGME; and</b>

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

304 fellows at that location.  
305  
306 The faculty must:  
307  
308 **II.B.1.a)** devote sufficient time to the educational program to fulfill  
309 their supervisory and teaching responsibilities; and to  
310 demonstrate a strong interest in the education of fellows;  
311 and,  
312  
313 **II.B.1.b)** administer and maintain an educational environment  
314 conducive to educating fellows in each of the ACGME  
315 competency areas.  
316  
317 **II.B.2.** The physician faculty must have current certification in the  
318 subspecialty by the American Board of Internal Medicine, or possess  
319 qualifications acceptable by the Review Committee.  
320  
321 **II.B.3.** The physician faculty must possess current medical licensure and  
322 appropriate medical staff appointment.  
323  
324 **II.B.4.** The nonphysician faculty must have appropriate qualifications in  
325 their field and hold appropriate institutional appointments.  
326  
327 **II.B.5.** The faculty must establish and maintain an environment of inquiry  
328 and scholarship with an active research component.  
329  
330 **II.B.5.a)** The faculty must regularly participate in organized clinical  
331 discussions, rounds, journal clubs, and conferences.  
332  
333 **II.B.5.b)** Some members of the faculty should also demonstrate  
334 scholarship by one or more of the following:  
335  
336 **II.B.5.b).(1)** peer-reviewed funding;  
337  
338 **II.B.5.b).(2)** publication of original research or review articles in  
339 peer-reviewed journals or chapters in textbooks;  
340  
341 **II.B.5.b).(3)** publication or presentation of case reports or clinical  
342 series at local, regional, or national professional and  
343 scientific society meetings; or,  
344  
345 **II.B.5.b).(4)** participation in national committees or educational  
346 organizations.  
347  
348 **II.B.5.c)** Faculty should encourage and support fellows in scholarly  
349 activities.  
350  
351 *II.B.6. The physician faculty must meet professional standards of ethical*  
352 *behavior.*  
353

- 354 II.B.7. Key Clinical Faculty  
355  
356 In addition to the program director, each program must have at least two  
357 Key Clinical Faculty (KCF). KCF are attending physicians who dedicate,  
358 on average, 10 hours per week throughout the year to the program. For  
359 programs with more than four fellows, ~~enrolled during the accredited~~  
360 ~~portion of the training program, a ratio of KCF to fellows of at least 1:~~  
361 there must be at least one KCF for every 1.5 fellows. ~~must be~~  
362 ~~maintained.~~  
363  
364 II.B.7.a) Key Clinical Faculty Qualifications  
365  
366 II.B.7.a).(1) KCF must be active clinicians with ~~broad~~ knowledge of,  
367 experience with, and commitment to ~~the internal medicine~~  
368 hematology as a discipline.  
369  
370 II.B.7.a).(2) KCF must have current ABIM certification in hematology.  
371  
372 II.B.7.b) *Key Clinical Faculty Responsibilities*  
373  
374 II.B.7.b).(1) *In addition to the responsibilities of all individual faculty*  
375 *members, the KCF ~~with and~~ the program director are*  
376 *responsible for the planning, implementation, monitoring*  
377 *and evaluation of the fellows' clinical and research*  
378 *education training.*  
379  
380 *II.B.7.b).(2) ~~The majority of~~ At least 50% of the KCF must demonstrate*  
381 *evidence of productivity in ~~the~~ scholarship, specifically,*  
382 *peer-reviewed funding; publication of original research,*  
383 *review articles, editorials, or case reports in peer-reviewed*  
384 *journals; or chapters in textbooks. ~~as defined in II.B.5.b.(1),~~*  
385 *~~or (2) above~~*  
386  
387 *II.B.7.b).(3) At least one of the KCF must:*  
388  
389 *II.B.7.b).(3).(a) be knowledgeable in the evaluation and*  
390 *assessment of the ACGME competencies; and,*  
391  
392 *II.B.7.b).(3).(b) spend significant time in the evaluation of fellows*  
393 *including the direct observation of fellows with*  
394 *patients.*  
395  
396 *II.B.7.b).(4) Appointment of one KCF to be an associate program*  
397 *director is suggested.*  
398  
399 II.B.8. *Clinical faculty members should participate in ~~prescribed~~ faculty*  
400 *development programs designed to enhance the effectiveness of their*  
401 *teaching.*  
402  
403 II.B.9. Faculty members who are subspecialty-certified by the American Board of  
404 Internal Medicine ABIM-certified in their respective disciplines of

405 endocrinology, gastroenterology, infectious disease, medical oncology,  
406 and pulmonary disease ~~must~~ should be available to participate in the  
407 education of fellows in hematology.  
408

409 **II.C. Other Program Personnel**

410  
411 **The institution and the program must jointly ensure the availability of all**  
412 **necessary professional, technical, and clerical personnel for the effective**  
413 **administration the program.**  
414

415 *II.C.1. There must be services available from other health care professionals,*  
416 *including dietitians, language interpreters, nurses, occupational*  
417 *therapists, physical therapists, and social workers.*  
418

419 *II.C.2. The fellowship must have access to surgeons in general surgery and*  
420 *surgical specialties, including surgeons with special interest in oncology.*  
421

422 *II.C.3. The fellowship must have access to other clinical specialists, ~~specifically~~*  
423 *including those in dermatology, obstetrics and gynecology, neurology,*  
424 *neurosurgery-neurological surgery, orthopedics, otolaryngology, and*  
425 *urology.*  
426

427 *II.C.4. There must be the availability of appropriate and timely consultation from*  
428 *other specialties.*  
429

430 *II.C.5. The following Expertise and in the following disciplines should be*  
431 *available to the program to provide multidisciplinary patient care and*  
432 *fellow education:*  
433

434 *II.C.5.a) genetic counseling;*

435  
436 *II.C.5.b) hospice and palliative care;*

437  
438 *II.C.5.c) oncologic nursing;*

439  
440 *II.C.5.d) pain management;*

441  
442 *II.C.5.e) psychiatry; and,*

443  
444 *II.C.5.f) rehabilitation medicine.*

445  
446 *II.C.5.g) dietetics;*

447  
448 *II.C.5.h) social services;*  
449

450 **II.D. Resources**

451  
452 **The institution and the program must jointly ensure the availability of**  
453 **adequate resources for fellow education, as defined in the specialty**  
454 **program requirements.**  
455

- 456 II.D.1. Space and Equipment  
 457  
 458 There must be space and equipment for the ~~educational~~ program,  
 459 including meeting rooms, ~~classrooms,~~ examination rooms, computers,  
 460 visual and other educational aids, and work/study space.  
 461
- 462 II.D.2. Facilities  
 463
- 464 II.D.2.a) Inpatient and outpatient systems must be in place to prevent  
 465 fellows from performing routine clerical functions, including  
 466 scheduling tests and appointments, and retrieving records and  
 467 letters.  
 468
- 469 II.D.2.b) The sponsoring institution must provide the broad range of  
 470 facilities and clinical support services required to provide  
 471 comprehensive care of adult patients. Fellows must have clinical  
 472 experiences in efficient, effective ambulatory and inpatient care  
 473 settings.  
 474
- 475 II.D.2.c) Fellows must have access to a lounge facility during assigned  
 476 duty hours.  
 477
- 478 II.D.2.d) When fellows are ~~assigned night duty~~ in the hospital, assigned  
 479 night duty, or called in from home, they must be provided with ~~on-~~  
 480 ~~call facilities that are convenient and that afford privacy, safety,~~  
 481 ~~and a restful environment with~~ a secure space for their  
 482 belongings.  
 483
- 484 II.D.2.e) Radiation oncology facilities must be available ~~at the primary-~~  
 485 ~~training site.~~  
 486
- 487 II.D.3. Laboratory and Imaging Services  
 488
- 489 | The following must be present at the primary clinical site or at  
 490 participating sites:  
 491
- 492 II.D.3.a) a hematology laboratory; ~~must be located at the primary training-~~  
 493 ~~site.~~  
 494
- 495 II.D.3.b) access to specialized coagulation laboratory ~~must be accessible.~~  
 496 (N.B.: ~~This~~ These may be located at institutions other than the  
 497 primary ~~training clinical~~ site.);  
 498
- 499 II.D.3.c) nuclear medicine imaging; ~~and must be accessible for the training-~~  
 500 ~~program.~~  
 501
- 502 II.D.3.d) cross-sectional imaging, including coaxial tomography (CT) and  
 503 magnetic resonance imaging (MRI); and,  
 504
- 505 | positron emission tomography (PET) scan imaging.  
 506

- 507 II.D.4. ~~Other Facilities, Resources, or Support Services~~
- 508
- 509 II.D.4.a) There must be advanced pathology services, including:
- 510
- 511 II.D.4.a).(1) immunopathology;
- 512
- 513 II.D.4.a).(2) blood banking (~~N.B.: These may be located at institutions-~~
- 514 ~~other than the primary training site.); and,~~
- 515
- 516 II.D.4.a).(3) transfusion and apheresis services ~~facilities~~.
- 517
- 518 II.D.4.b) There ~~should~~ must be a medical oncology clinical program with
- 519 which hematology fellows may interact ~~formally in an educational-~~
- 520 ~~experience.~~
- 521
- 522 *II.D.5. Medical Records*
- 523
- 524 Access to an electronic health record should be provided. In the absence
- 525 of an existing electronic health record, institutions must demonstrate
- 526 institutional commitment to its development, and progress towards its
- 527 implementation.
- 528
- 529 II.D.6. Patient Population
- 530
- 531 II.D.6.a) The patient population must have a variety of hematologic
- 532 disorders.
- 533
- 534 *II.D.6.b) There must be patients of each ~~both sexes~~-gender, with a broad*
- 535 *age range, including geriatric patients.*
- 536
- 537 *II.D.6.c) A sufficient number of patients must be available to enable ~~ensure~~*
- 538 *~~adequate inpatient and ambulatory experience for each fellow to~~ to*
- 539 *achieve the required educational outcomes.*
- 540
- 541 **II.E. Medical Information Access**
- 542
- 543 **Fellows must have ready access to specialty-specific and other appropriate**
- 544 **reference material in print or electronic format. Electronic medical literature**
- 545 **databases with search capabilities should be available.**
- 546
- 547 **III. Fellow Appointments**
- 548
- 549 **III.A. Eligibility Criteria**
- 550
- 551 **The program director must comply with the criteria for fellow eligibility as**
- 552 **specified in the Institutional Requirements.**
- 553
- 554 *III.A.1. ~~Prior to appointment in the fellowship program,~~ fellows should have*
- 555 *completed an ACGME-accredited internal medicine ~~education~~ program.*
- 556
- 557 *III.A.2. ~~Fellows from non-ACGME-accredited internal medicine education-~~*

- 558 *programs must have completed at least three years of internal medicine*  
559 *education prior to starting the fellowship.*  
560
- 561 III.A.3. *The program director must inform ~~non-ACGME-trained~~ applicants from*  
562 *non-ACGME-accredited programs, prior to appointment and in writing, of*  
563 *the ABIM policies and procedures that ~~may~~ will affect ~~the fellows~~ their*  
564 *eligibility for ABIM certification.*  
565
- 566 III.A.4. *When averaged over any five-year period, a minimum of 75% of fellows in*  
567 *each ~~subspecialty training~~ program must be graduates of an ACGME-*  
568 *accredited internal medicine ~~training~~ program. ~~Non-ACGME internal~~*  
569 *medicine trained fellows must have at least three years of internal*  
570 *medicine training prior to starting fellowship.*  
571
- 572 III.B. **Number of Fellows**  
573  
574 **The program director may not appoint more fellows than approved by the**  
575 **Review Committee, unless otherwise stated in the specialty-specific**  
576 **requirements. The program’s educational resources must be adequate to**  
577 **support the number of fellows appointed to the program.**  
578
- 579 III.B.1. *The ~~minimum~~ number of available fellow positions in the training program*  
580 *must be at least one per year ~~not be less than the number of accredited~~*  
581 *training years in the program.*  
582
- 583 III.C. **Fellow Transfers**  
584
- 585 III.C.1. **Before accepting a fellow who is transferring from another program,**  
586 **the program director must obtain written or electronic verification of**  
587 **previous educational experiences and a summative competency-**  
588 **based performance evaluation of the transferring fellow.**  
589
- 590 III.C.2. **A program director must provide timely verification of fellowship**  
591 **education and summative performance evaluations for fellows who**  
592 **leave the program prior to completion.**  
593
- 594 III.D. **Appointment of Fellows and Other Learners**  
595  
596 **The presence of other learners (including, but not limited to, residents from**  
597 **other specialties, subspecialty fellows, PhD students, and nurse**  
598 **practitioners) in the program must not interfere with the appointed fellows'**  
599 **education. The program director must report the presence of other learners**  
600 **to the DIO and GMEC in accordance with sponsoring institution guidelines.**  
601
- 602 IV. **Educational Program**  
603
- 604 IV.A. **The curriculum must contain the following educational components:**  
605
- 606 IV.A.1. **Overall educational goals for the program, which the program must**  
607 **distribute to fellows and faculty annually;**

- 608
- 609 **IV.A.2. Competency-based goals and objectives for each assignment at**
- 610 **each educational level, which the program must distribute to fellows**
- 611 **and faculty annually, in either written or electronic form. These**
- 612 **should be reviewed by the fellow at the start of each rotation;**
- 613
- 614 **IV.A.3. Regularly scheduled didactic sessions;**
- 615
- 616 *IV.A.3.a) The core curriculum must include a didactic program based upon*
- 617 *the core knowledge content in the subspecialty area.*
- 618
- 619 *IV.A.3.a).(1) The program must afford each fellow an opportunity to*
- 620 *review topics covered in conferences that he or she was*
- 621 *unable to attend.*
- 622
- 623 *IV.A.3.a).(2) Fellows must participate in clinical case conferences,*
- 624 *journal clubs, research conferences, and morbidity and*
- 625 *mortality or quality improvement conferences.*
- 626
- 627 *IV.A.3.a).(3) All core conferences must have at least one faculty*
- 628 *member present, and must be scheduled as to ensure*
- 629 *peer-peer and peer-faculty interaction.*
- 630
- 631 *IV.A.3.b) Patient-based teaching must include direct interaction between*
- 632 *fellows and attending-faculty members, bedside teaching,*
- 633 *discussion of pathophysiology, and the use of current evidence in*
- 634 *diagnostic and therapeutic decisions. The teaching must be:*
- 635
- 636 | *IV.A.3.b).(1) formally conducted on all inpatient, outpatient, and*
- 637 *consultative services; and,*
- 638
- 639 *IV.A.3.b).(2) conducted with a frequency and duration sufficient to that*
- 640 *ensures a meaningful and continuous teaching relationship*
- 641 *between the assigned supervising faculty member(s)*
- 642 *teaching attending and fellows.*
- 643
- 644 *IV.A.3.c) Fellows must receive instruction in practice management relevant*
- 645 *to hematology.*
- 646
- 647 **IV.A.4. Delineation of fellow responsibilities for patient care, progressive**
- 648 **responsibility for patient management, and supervision of fellows**
- 649 **over the continuum of the program.**
- 650
- 651 **IV.A.5. ACGME Competencies**
- 652
- 653 **The program must integrate the following ACGME competencies**
- 654 **into the curriculum:**
- 655
- 656 **IV.A.5.a) Patient Care**
- 657
- 658 **Fellows must be able to provide patient care that is**

**compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows:**

- 659  
660  
661  
662 IV.A.5.a).(1) *must demonstrate competence in the practice of health*  
663 *promotion, disease prevention, diagnosis, care, and*  
664 *treatment of ~~men and women~~ patients of each gender,*  
665 *from adolescence to old age, during health and all stages*  
666 *of illness;*  
667  
668 IV.A.5.a).(2) must demonstrate competence as a consultant;  
669  
670 IV.A.5.a).(3) ~~must have formal instruction, clinical experience, and~~  
671 ~~demonstrate competence in the: prevention,~~  
672  
673 IV.A.5.a).(3).(a) evaluation and management of diagnosis,  
674 pathology, staging, and management of neoplastic  
675 disorders of the:  
676  
677 IV.A.5.a).(3).(a).(i) lymphoid organs; and,  
678  
679 IV.A.5.a).(3).(a).(ii) hematopoietic system.  
680  
681 IV.A.5.a).(3).(b) use of chemotherapeutic drugs, biologic products,  
682 and growth factors, as well as their mechanisms of  
683 action, pharmacokinetics, clinical indications, and  
684 limitations, including their effects, toxicity, and  
685 interactions;  
686  
687 IV.A.5.a).(3).(c) use of multiagent chemotherapeutic protocols and  
688 combined modality therapy of hematologic  
689 malignancies;  
690  
691 IV.A.5.a).(3).(d) role and use of hematologic, infectious disease,  
692 and nutrition support;  
693  
694 IV.A.5.a).(3).(e) management of the neutropenic and the  
695 immunocompromised patient;  
696  
697 IV.A.5.a).(3).(f) management of pain, anxiety, and depression in  
698 patients with hematologic disorders;  
699  
700 IV.A.5.a).(3).(g) rehabilitation and psychosocial care of patients with  
701 hematologic disorders;  
702  
703 IV.A.5.a).(3).(h) palliative care, including hospice and home care;  
704  
705 IV.A.5.a).(3).(i) treatment and diagnosis of paraneoplastic  
706 disorders;  
707  
708 IV.A.5.a).(3).(j) care of patients with human immunodeficiency  
709 virus-related malignancies;

710		
711	IV.A.5.a).(3).(k)	care and management of the geriatric patients with hematologic disorders;
712		
713		
714	IV.A.5.a).(3).(l)	correlation of clinical information with cytology, histology, and immunodiagnostic imaging techniques;
715		
716		
717		
718	IV.A.5.a).(3).(m)	tests of hemostasis and thrombosis for both congenital and acquired disorders and regulation of antithrombotic therapy;
719		
720		
721		
722	IV.A.5.a).(3).(n)	treatment of patients with acquired and congenital disorders of hemostasis and thrombosis, including the biochemistry and pharmacology of coagulation factor replacement therapy and use of antithrombotic therapy;
723		
724		
725		
726		
727		
728	IV.A.5.a).(3).(o)	multidisciplinary management of hematologic malignancies;
729		
730		
731	IV.A.5.a).(3).(p)	indications and application of imaging techniques in patients with neoplastic and blood disorders;
732		
733		
734	IV.A.5.a).(3).(q)	management and care of indwelling access catheters;
735		
736		
737	IV.A.5.a).(3).(r)	use of chemotherapeutic agents and biological products through all therapeutic routes;
738		
739		
740	IV.A.5.a).(3).(s)	assessment of hematologic disorders by <del>computed tomography-CT, magnetic resonance-MRI, positron emission tomography (PET)</del> scanning, and nuclear imaging techniques;
741		
742		
743		
744		
745	IV.A.5.a).(3).(t)	performance of assessment and interpretation of <del>the following</del> : complete blood count, including platelet and white cell differential, by means of automated or manual techniques, with appropriate quality control;
746		
747		
748		
749		
750		
751	IV.A.5.a).(3).(u)	performance and interpretation of bone marrow aspiration and biopsy;
752		
753		
754	IV.A.5.a).(3).(v)	preparation staining and interpretation of blood smears, bone marrow aspirates, and touch preparations, as well as interpretation of bone marrow biopsies;
755		
756		
757		
758		
759	IV.A.5.a).(3).(w)	performance and interpretation of lumbar puncture <u>and interpretation of cerebrospinal fluid;</u>
760		

- 761  
 762 IV.A.5.a).(3).(x) access and care of Ommaya reservoir;  
 763  
 764 IV.A.5.a).(3).(y) intrathecal administration of chemotherapeutic  
 765 agents; and,  
 766  
 767 IV.A.5.a).(3).(z) care and management of venous access devices.  
 768

769 **IV.A.5.b)**

**Medical Knowledge**

770  
 771 **Fellows must demonstrate knowledge of established and**  
 772 **evolving biomedical, clinical, epidemiological and social-**  
 773 **behavioral sciences, as well as the application of this**  
 774 **knowledge to patient care. Fellows:**  
 775

- 776 IV.A.5.b).(1) must demonstrate knowledge of ~~are expected to learn the~~  
 777 scientific method of problem solving and evidence-based  
 778 decision making; ~~a commitment to lifelong learning, and~~  
 779 ~~an attitude of caring that is derived from humanistic and~~  
 780 ~~professional values.~~  
 781

- 782 IV.A.5.b).(2) must ~~develop~~ demonstrate knowledge understanding of  
 783 indications, contraindications, limitations, complications,  
 784 techniques, and interpretation of results of those diagnostic  
 785 and therapeutic procedures integral to the discipline,  
 786 including the appropriate indications for and use of  
 787 screening tests/procedures.  
 788

- 789 IV.A.5.b).(3) must demonstrate knowledge of pathogenesis, diagnosis,  
 790 and treatment of disease, including:  
 791

- 792 IV.A.5.b).(3).(a) basic molecular and pathophysiologic mechanisms,  
 793 diagnosis, and therapy of diseases of the blood,  
 794 including anemias, diseases of white blood cells  
 795 and stem cells, and disorders of hemostasis and  
 796 thrombosis; and,  
 797

- 798 IV.A.5.b).(3).(b) etiology, epidemiology, natural history, diagnosis,  
 799 pathology, staging, and management of neoplastic  
 800 diseases of the blood, blood-forming organs, and  
 801 lymphatic tissues.  
 802

- 803 IV.A.5.b).(4) must demonstrate knowledge of genetics and  
 804 developmental biology, including:  
 805

- 806 IV.A.5.b).(4).(a) molecular genetics;

- 807  
 808 IV.A.5.b).(4).(b) prenatal diagnosis;

- 809  
 810 IV.A.5.b).(4).(c) the nature of oncogenes and their products; and,  
 811

812	IV.A.5.b).(4).(d)	cytogenetics.
813		
814	IV.A.5.b).(5)	<u>must demonstrate knowledge of physiology and</u>
815		<u>pathophysiology, including:</u>
816		
817	IV.A.5.b).(5).(a)	cell and molecular biology;
818		
819	IV.A.5.b).(5).(b)	hematopoiesis;
820		
821	IV.A.5.b).(5).(c)	principles of oncogenesis;
822		
823	IV.A.5.b).(5).(d)	tumor immunology;
824		
825	IV.A.5.b).(5).(e)	molecular mechanisms of hematopoietic and
826		lymphopoietic malignancies;
827		
828	IV.A.5.b).(5).(f)	basic and clinical pharmacology, pharmacokinetics,
829		and toxicity; and,
830		
831	IV.A.5.b).(5).(g)	pathophysiology and patterns of tumor metastases.
832		
833	IV.A.5.b).(6)	<u>must demonstrate knowledge of:</u>
834		
835	IV.A.5.b).(6).(a)	clinical epidemiology and biostatistics, <del>including to</del>
836		<del>include</del> clinical study and experimental protocol
837		design, data collection, and analysis;
838		
839	IV.A.5.b).(6).(a).(i)	<del>clinical epidemiology and medical statistics;</del>
840		<del>and</del>
841		
842	IV.A.5.b).(6).(a).(ii)	<del>clinical study and experimental protocol</del>
843		<del>design, data collection, and analysis.</del>
844		
845	IV.A.5.b).(6).(b)	basic principles of laboratory and clinical testing,
846		quality control, quality assurance, and proficiency
847		standards;
848		
849	IV.A.5.b).(6).(c)	immune markers, immunophenotyping, flow
850		cytometry, cytochemical studies, and cytogenetic
851		and DNA analysis of neoplastic disorders;
852		
853	IV.A.5.b).(6).(d)	malignant and hematologic complications of organ
854		transplantation;
855		
856	IV.A.5.b).(6).(e)	gene therapy;
857		
858	IV.A.5.b).(6).(f)	effects of systemic disorders and drugs on the
859		blood, blood-forming organs, and lymphatic tissues;
860		
861	IV.A.5.b).(6).(g)	transfusion medicine, including the evaluation of
862		antibodies, blood compatibility, and the indications

863		for and complications of blood component therapy and apheresis procedures;
864		
865		
866	IV.A.5.b).(6).(h)	acquired and congenital disorders of red cells, white cells, platelets and stem cells; and,
867		
868		
869	IV.A.5.b).(6).(i)	hematopoietic and lymphopoietic malignancies, including disorders of plasma cells.
870		
871		
872	IV.A.5.b).(7)	<u>must demonstrate knowledge of</u> principles of, indications for, and limitations of radiation therapy in the treatment of cancer;
873		
874		
875		
876	IV.A.5.b).(8)	<u>must demonstrate knowledge of</u> principles of, indications for, and complications of autologous and allogeneic bone marrow or peripheral blood stem cell transplantation;
877		
878		
879		
880	IV.A.5.b).(9)	<u>must demonstrate knowledge of principles of, indications for,</u> and complications of peripheral stem cell harvests;
881		
882		
883	IV.A.5.b).(10)	<u>must demonstrate knowledge of the</u> management of post-transplant complications; and,
884		
885		
886	IV.A.5.b).(11)	<del>the use of chemotherapeutic drugs, biologic products, and growth factors;</del> their mechanisms of action, pharmacokinetics, clinical indications <u>for,</u> and limitations <u>of chemotherapeutic drugs, biologic products, and growth factors,</u> including their effects, toxicity, and interactions.
887		
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890		
891		
892	<b>IV.A.5.c)</b>	<b>Practice-based Learning and Improvement</b>
893		
894		<b>Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Fellows are expected to develop skills and habits to be able to meet the following goals:</b>
895		
896		
897		
898		
899		
900		
901	IV.A.5.c).(1)	<b>identify strengths, deficiencies, and limits in one's knowledge and expertise;</b>
902		
903		
904	IV.A.5.c).(2)	<b>set learning and improvement goals;</b>
905		
906	IV.A.5.c).(3)	<b>identify and perform appropriate learning activities;</b>
907		
908	IV.A.5.c).(4)	<b>systematically analyze practice, using quality improvement methods, and implement changes with the goal of practice improvement;</b>
909		
910		
911		
912	IV.A.5.c).(5)	<b>incorporate formative evaluation feedback into daily</b>

- 913 practice;
- 914
- 915 **IV.A.5.c).(6)** locate, appraise, and assimilate evidence from
- 916 scientific studies related to their patients' health
- 917 problems;
- 918
- 919 **IV.A.5.c).(7)** use information technology to optimize learning;
- 920
- 921 **IV.A.5.c).(8)** participate in the education of patients, families,
- 922 students, fellows and other health professionals; and
- 923
- 924 **IV.A.5.c).(9)** *obtain procedure-specific informed consent by competently*
- 925 *educating patients about rationale, technique, and*
- 926 *complications of procedures.*
- 927

**IV.A.5.d)**

**Interpersonal and Communication Skills**

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

- 934
- 935 **IV.A.5.d).(1)** communicate effectively with patients, families, and
- 936 the public, as appropriate, across a broad range of
- 937 socioeconomic and cultural backgrounds;
- 938
- 939 **IV.A.5.d).(2)** communicate effectively with physicians, other health
- 940 professionals, and health related agencies;
- 941
- 942 **IV.A.5.d).(3)** work effectively as a member or leader of a health care
- 943 team or other professional group;
- 944
- 945 **IV.A.5.d).(4)** act in a consultative role to other physicians and
- 946 health professionals;
- 947
- 948 **IV.A.5.d).(5)** maintain comprehensive, timely, and legible medical
- 949 records, if applicable;
- 950
- 951 **IV.A.5.d).(6)** demonstrate team leadership skills and ability to work with
- 952 an interdisciplinary team by:
- 953
- 954 **IV.A.5.d).(6).(a)** identifying essential team members;
- 955
- 956 **IV.A.5.d).(6).(b)** defining the roles of team members; and,
- 957
- 958 **IV.A.5.d).(6).(c)** evaluating the role of the interdisciplinary team.
- 959

**IV.A.5.e)**

**Professionalism**

**Fellows must demonstrate a commitment to carrying out**

960  
961  
962

963		<b>professional responsibilities and an adherence to ethical principles. Fellows are expected to demonstrate:</b>
964		
965		
966	<b>IV.A.5.e).(1)</b>	<b>compassion, integrity, and respect for others;</b>
967		
968	<b>IV.A.5.e).(2)</b>	<b>responsiveness to patient needs that supersedes self-interest;</b>
969		
970		
971	<b>IV.A.5.e).(3)</b>	<b>respect for patient privacy and autonomy;</b>
972		
973	<b>IV.A.5.e).(4)</b>	<b>accountability to patients, society and the profession;</b>
974		
975	<b>IV.A.5.e).(5)</b>	<b>sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation;</b>
976		
977		
978		
979		
980	<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;</u></i>
981		
982		
983		
984		
985	<i>IV.A.5.e).(7)</i>	<i>a commitment to lifelong learning, and an attitude of caring derived from humanistic and professional values; and,</i>
986		
987		
988	<i>IV.A.5.e).(8)</i>	<i>personal development, attitudes, and coping skills of physicians and other health care professionals who care for critically-ill patients.</i>
989		
990		
991		
992	<b>IV.A.5.f)</b>	<b>Systems-based Practice</b>
993		
994		<b>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.</b>
995		
996		
997		
998		<b>Fellows are expected to:</b>
999		
1000	<b>IV.A.5.f).(1)</b>	<b>work effectively in various health care delivery settings and systems relevant to their clinical specialty;</b>
1001		
1002		
1003		
1004	<b>IV.A.5.f).(2)</b>	<b>coordinate patient care within the health care system relevant to their clinical specialty;</b>
1005		
1006		
1007	<b>IV.A.5.f).(3)</b>	<b>incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;</b>
1008		
1009		
1010		
1011	<b>IV.A.5.f).(4)</b>	<b>advocate for quality patient care and optimal patient care systems;</b>
1012		

1013		
1014	<b>IV.A.5.f).(5)</b>	<b>work in interprofessional teams to enhance patient safety and improve patient care quality; and</b>
1015		
1016		
1017	<b>IV.A.5.f).(6)</b>	<b>participate in identifying system errors and implementing potential systems solutions.</b>
1018		
1019		
1020	IV.A.6.	<u>Curriculum Organization and Fellow Experiences</u>
1021		
1022	IV.A.6.a)	A minimum of 12 months must be devoted to clinical experience.
1023		
1024	IV.A.6.a).(1)	The program must provide at least one month of clinical experience in autologous and allogeneic bone marrow transplantation.
1025		
1026		
1027		
1028	IV.A.6.b)	<u>Fellows must participate in training using simulation.</u>
1029		
1030	IV.A.6.c)	Inpatient assignments should be of sufficient duration to permit continuing care of a majority of the patients throughout their hospitalization.
1031		
1032		
1033		
1034	IV.A.6.d)	<del>The program Fellows must also participate in a multidisciplinary case management or tumor board conferences and in protocol studies.</del>
1035		
1036		
1037		
1038	IV.A.6.e)	Fellows must assume continuing responsibility for acutely- and chronically-ill patients in order to observe and manage both inpatients and outpatients with a wide variety of blood and neoplastic disorders, and the benefits and adverse effects of therapy.
1039		
1040		
1041		
1042		
1043		
1044	IV.A.6.f)	<u>Fellows should participate in the care of patients undergoing:</u>
1045		
1046	IV.A.6.f).(1)	apheresis procedures; and,
1047		
1048	IV.A.6.f).(2)	bone marrow or peripheral stem cell harvest for transplantation.
1049		
1050		
1051	IV.A.6.g)	<u>Fellows must be educated about and should have experience with:</u>
1052		
1053		
1054	IV.A.6.g).(1)	performance and interpretation of partial thromboplastin time, prothrombin time, platelet aggregation, and bleeding time, as well as other standard <u>and specialized</u> coagulation assays; and,
1055		
1056		
1057		
1058		
1059	IV.A.6.g).(2)	test of hemostasis.
1060		
1061	IV.A.6.h)	Experience with Continuity Ambulatory Patients
1062		
1063		<i>Fellows must have continuity ambulatory clinic experience to</i>

1064 ~~develop a continuous healing relationship with patients for whom~~  
1065 ~~they provide hematology care. This continuity experience should~~  
1066 ~~expose that exposes them fellows to the breadth and depth of the~~  
1067 ~~hematology.~~

1069 IV.A.6.h).(1) Overall-This experience should average one half-day each  
1070 week.

1072 IV.A.6.h).(2) Overall-This experience must include an appropriate  
1073 distribution of patients of each ~~both sexes~~-gender and a  
1074 diversity of ages, which. ~~This should be accomplished by~~  
1075 through either:

1077 IV.A.6.h).(2).(a) a continuity clinic which provides fellows the  
1078 opportunity to learn the course of disease; or,

1080 IV.A.6.h).(2).(b) selected blocks of at least six months which  
1081 address specific areas of hematologic disorders.

1083 IV.A.6.h).(3) Each fellow should, on average, be responsible for four to  
1084 eight patients during each half-day session.

1086 IV.A.6.h).(4) The continuing patient care experience should not be  
1087 interrupted by more than one month, excluding a fellow's  
1088 vacation.

1090 IV.A.6.h).(5) ~~It is suggested that~~ Fellows should be informed of the  
1091 status of their continuity patients when they such patients  
1092 are hospitalized, as clinically appropriate. ~~so the fellows~~  
1093 ~~can make appropriate arrangements to maintain continuity~~  
1094 ~~of care.~~

1096 IV.A.6.i) Procedures and Technical Skills

1098 IV.A.6.i).(1) Direct faculty supervision of procedures performed by each  
1099 fellow must occur until proficiency has been acquired and  
1100 documented by the program director.

1102 IV.A.6.i).(2) ~~A skilled preceptor~~ Faculty members must be available to  
1103 teach and supervise the fellows in the performance and  
1104 interpretation of these procedures, ~~Procedures which~~  
1105 must be documented in each fellow's record, including  
1106 indications, outcomes, diagnoses, and supervisor(s).

1108 IV.A.6.j) The Fellows must have experience ~~be given opportunities to~~  
1109 ~~function~~ in the role of an hematology consultant in both the  
1110 inpatient and outpatient settings.

1112 **IV.B. Fellows' Scholarly Activities**

1114 **IV.B.1. The curriculum must advance fellows' knowledge of the basic**

- 1115 principles of research, including how research is conducted,  
 1116 evaluated, explained to patients, and applied to patient care.  
 1117  
 1118 **IV.B.2. Fellows should participate in scholarly activity.**  
 1119  
 1120 *IV.B.2.a) The majority of fellows must demonstrate evidence of ~~recent~~*  
 1121 *~~research productivity~~ scholarship conducted during the fellowship*  
 1122 *through one or more of the following:*  
 1123  
 1124 *IV.B.2.a).(1) publication of articles, book chapters, abstracts or case*  
 1125 *reports in peer-reviewed journals;*  
 1126  
 1127 *IV.B.2.a).(2) publication of peer-reviewed performance improvement or*  
 1128 *education research;*  
 1129  
 1130 *IV.B.2.a).(3) peer-reviewed funding; or,*  
 1131  
 1132 *IV.B.2.a).(4) peer-reviewed abstracts presented at regional, state or*  
 1133 *national specialty meetings.*  
 1134  
 1135 **IV.B.3. The sponsoring institution and program should allocate adequate**  
 1136 **educational resources to facilitate fellow involvement in scholarly**  
 1137 **activities.**  
 1138  
 1139 **V. Evaluation**  
 1140  
 1141 **V.A. Fellow**  
 1142  
 1143 **V.A.1. Formative Evaluation**  
 1144  
 1145 **V.A.1.a) The faculty must evaluate fellow performance in a timely**  
 1146 **manner during each rotation or similar educational**  
 1147 **assignment, and document this evaluation at completion of**  
 1148 **the assignment.**  
 1149  
 1150 *V.A.1.a).(1) The faculty must discuss this evaluation with ~~the~~ each*  
 1151 *fellow at the completion of ~~the~~ each assignment.*  
 1152  
 1153 *V.A.1.a).(2) Assessment of procedural competence should include a*  
 1154 *formal evaluation process and not be based solely on a*  
 1155 *minimum number of procedures performed.*  
 1156  
 1157 **V.A.1.b) The program must:**  
 1158  
 1159 **V.A.1.b).(1) provide objective assessments of competence in**  
 1160 **patient care, medical knowledge, practice-based**  
 1161 **learning and improvement, interpersonal and**  
 1162 **communication skills, professionalism, and systems-**  
 1163 **based practice;**  
 1164

1165	V.A. 1.b).(1).(a)	<u>Patient Care</u>
1166		
1167		<u>The program must assess the fellow in data</u>
1168		<u>gathering, clinical reasoning, patient management</u>
1169		<u>and procedures in both the inpatient and outpatient</u>
1170		<u>setting. This assessment must involve direct</u>
1171		<u>observation of fellow-patient encounters.</u>
1172		
1173	V.A. 1.b).(1).(a).(i)	<u>Each program must define a standard</u>
1174		<u>criteria for proficiency competence for all</u>
1175		<u>required and elective procedures.</u>
1176		
1177	V.A. 1.b).(1).(a).(ii)	<u>The record of evaluation must include the</u>
1178		<u>fellow's logbook or an equivalent method to</u>
1179		<u>demonstrate that each fellow has achieved</u>
1180		<u>competence in the performance of required</u>
1181		<u>procedures.</u>
1182		
1183	V.A. 1.b).(1).(b)	<u>Medical Knowledge</u>
1184		
1185		<u>The program must use an objective formative</u>
1186		<u>assessment method. The same formative</u>
1187		<u>assessment method must be administered at least</u>
1188		<u>twice during the program.</u>
1189		
1190	V.A. 1.b).(1).(c)	<u>Practice-based learning and Improvement</u>
1191		
1192		<u>The program must use performance data to assess</u>
1193		<u>the fellow in:</u>
1194		
1195	V.A. 1.b).(1).(c).(i)	<u>application of evidence to patient care;</u>
1196		
1197	V.A. 1.b).(1).(c).(ii)	<u>practice improvement;</u>
1198		
1199	V.A. 1.b).(1).(c).(iii)	<u>teaching skills involving peers and patients;</u>
1200		<u>and,</u>
1201		
1202	V.A. 1.b).(1).(c).(iv)	<u>scholarship.</u>
1203		
1204	V.A. 1.b).(1).(d)	<u>Interpersonal and Communication Skills</u>
1205		
1206		<u>The program must use both direct observation and</u>
1207		<u>multi-source evaluation, including patients, peers</u>
1208		<u>and non-physician team members, to assess fellow</u>
1209		<u>performance in:</u>
1210		
1211	V.A. 1.b).(1).(d).(i)	<u>communication with patient and family;</u>
1212		
1213	V.A. 1.b).(1).(d).(ii)	<u>teamwork;</u>
1214		
1215	V.A. 1.b).(1).(d).(iii)	<u>communication with peers, including</u>

1216		<u>transitions in care; and,</u>
1217		
1218	V.A. 1.b).(1).(d).(iv)	<u>record keeping.</u>
1219		
1220	V.A. 1.b).(1).(e)	<u>Professionalism</u>
1221		
1222		<u>The program must use multi-source evaluation,</u>
1223		<u>including patients, peers, and non-physician team</u>
1224		<u>members, to assess each fellow:</u>
1225		
1226	V.A. 1.b).(1).(e).(i)	<u>honesty and integrity;</u>
1227		
1228	V.A. 1.b).(1).(e).(ii)	<u>ability to meet professional responsibilities;</u>
1229		
1230	V.A. 1.b).(1).(e).(iii)	<u>ability to maintain appropriate professional</u>
1231		<u>relationships with patients and colleagues;</u>
1232		<u>and,</u>
1233		
1234	V.A. 1.b).(1).(e).(iv)	<u>commitment to self-improvement.</u>
1235		
1236	V.A. 1.b).(1).(f)	<u>Systems-based Practice</u>
1237		
1238		<u>The program must use multi-source evaluation,</u>
1239		<u>including peers, and non-physician team members,</u>
1240		<u>to assess each fellow's:</u>
1241		
1242	V.A. 1.b).(1).(f).(i)	<u>ability to provide care coordination,</u>
1243		<u>including transition of care;</u>
1244		
1245	V.A. 1.b).(1).(f).(ii)	<u>ability to work in interdisciplinary teams;</u>
1246		
1247	V.A. 1.b).(1).(f).(iii)	<u>advocacy for quality of care; and,</u>
1248		
1249	V.A. 1.b).(1).(f).(iv)	<u>ability to identify system problems and</u>
1250		<u>participate in improvement activities.</u>
1251		
1252	<b>V.A.1.b).(2)</b>	<b>use multiple evaluators (e.g., faculty, peers, patients,</b>
1253		<b>self, and other professional staff);</b>
1254		
1255	<b>V.A.1.b).(3)</b>	<b>document progressive fellow performance</b>
1256		<b>improvement appropriate to educational level; and</b>
1257		
1258	<b>V.A.1.b).(4)</b>	<b>provide each fellow with documented semiannual</b>
1259		<b>evaluation of performance with feedback.</b>
1260		
1261	V.A.1.b).(4).(a)	<i>Fellows' performance in continuity clinic must be</i>
1262		<i>reviewed with them verbally and in writing at least</i>
1263		<i>semiannually.</i>
1264		
1265	<b>V.A.1.c)</b>	<b>The evaluations of fellow performance must be accessible for</b>
1266		<b>review by the fellow, in accordance with institutional policy.</b>

- 1267
- 1268 **V.A.2. Summative Evaluation**
- 1269
- 1270 **The program director must provide a summative evaluation for each**
- 1271 **fellow upon completion of the program. This evaluation must**
- 1272 **become part of the fellow's permanent record maintained by the**
- 1273 **institution, and must be accessible for review by the fellow in**
- 1274 **accordance with institutional policy. This evaluation must:**
- 1275
- 1276 **V.A.2.a) document the fellow's performance during the final period of**
- 1277 **education; and**
- 1278
- 1279 **V.A.2.b) verify that the fellow has demonstrated sufficient competence**
- 1280 **to enter practice without direct supervision.**
- 1281
- 1282 **V.B. Faculty Evaluation**
- 1283
- 1284 **V.B.1. At least annually, the program must evaluate faculty performance as**
- 1285 **it relates to the educational program.**
- 1286
- 1287 **V.B.2. These evaluations should include a review of faculty's clinical**
- 1288 **teaching abilities, commitment to the educational program, clinical**
- 1289 **knowledge, professionalism, and scholarly activities.**
- 1290
- 1291 **V.B.3. This evaluation must include at least annual written confidential**
- 1292 **evaluations by fellows.**
- 1293
- 1294 *V.B.3.a) ~~In addition, Fellows must have the opportunity to provide~~*
- 1295 *~~confidential written evaluations of each supervising faculty~~*
- 1296 *~~member at the end of a each rotation.~~*
- 1297
- 1298 *V.B.3.b) ~~The program director must be reviewed t~~These evaluations must*
- 1299 *be reviewed with each attending faculty member annually.*
- 1300
- 1301 **V.C. Program Evaluation and Improvement**
- 1302
- 1303 **V.C.1. The program must document formal, systematic evaluation of the**
- 1304 **curriculum at least annually. The program must monitor and track**
- 1305 **each of the following areas:**
- 1306
- 1307 **V.C.1.a) fellow performance;**
- 1308
- 1309 **V.C.1.b) faculty development;**
- 1310
- 1311 **V.C.1.c) graduate performance, including performance of program**
- 1312 **graduates on the certification examination; and**
- 1313
- 1314 *V.C.1.c).(1) At least 80% of program's graduating fellows from those*
- 1315 *eligible to take an ABIM subspecialty certifying*
- 1316 *examination upon completion of their training for the most*

- 1317 *recently defined five year period who are eligible should*  
 1318 *must have taken an the ABIM subspecialty certifying*  
 1319 *examination. (Note: Five-year rolling pass rate for first time*  
 1320 *takers of the ABIM certifying examination will be examined*  
 1321 *at each program review).*  
 1322  
 1323 V.C.1.c).(2) *At least 80% of a program's graduates taking the ABIM*  
 1324 *certifying examination for the first time during the most*  
 1325 *recently defined five year period should pass.*  
 1326  
 1327 V.C.1.d) **program quality. Specifically:**  
 1328  
 1329 V.C.1.d).(1) **Fellows and faculty must have the opportunity to**  
 1330 **evaluate the program confidentially and in writing at**  
 1331 **least annually.**  
 1332  
 1333 V.C.1.d).(2) **The program must use the results of fellows'**  
 1334 **assessments of the program together with other**  
 1335 **program evaluation results to improve the program.**  
 1336  
 1337 V.C.1.d).(3) *At least 80% of the entering fellows should have*  
 1338 *completed the program when averaged over a five-year*  
 1339 *period.*  
 1340  
 1341 V.C.2. **If deficiencies are found, the program should prepare a written plan**  
 1342 **of action to document initiatives to improve performance in the**  
 1343 **areas listed in section V.C.1. The action plan should be reviewed**  
 1344 **and approved by the teaching faculty and documented in meeting**  
 1345 **minutes.**  
 1346  
 1347 V.C.3. *Representative program personnel, at a minimum to include the program*  
 1348 *director, representative faculty, and one fellow, must review program*  
 1349 *goals and objectives, and the effectiveness with which they are achieved.*  
 1350  
 1351 VI. **Fellow Duty Hours in the Learning and Working Environment**  
 1352  
 1353 VI.A. **Professionalism, Personal Responsibility, and Patient Safety**  
 1354  
 1355 VI.A.1. **Programs and sponsoring institutions must educate fellows and**  
 1356 **faculty members concerning the professional responsibilities of**  
 1357 **physicians to appear for duty appropriately rested and fit to provide**  
 1358 **the services required by their patients.**  
 1359  
 1360 VI.A.2. **The program must be committed to and responsible for promoting**  
 1361 **patient safety and fellow well-being in a supportive educational**  
 1362 **environment.**  
 1363  
 1364 VI.A.3. **The program director must ensure that fellows are integrated and**  
 1365 **actively participate in interdisciplinary clinical quality improvement**  
 1366 **and patient safety programs.**

- 1367  
1368 **VI.A.4.**                   **The learning objectives of the program must:**  
1369  
1370 **VI.A.4.a)**                   **be accomplished through an appropriate blend of supervised**  
1371 **patient care responsibilities, clinical teaching, and didactic**  
1372 **educational events; and,**  
1373  
1374 **VI.A.4.b)**                   **not be compromised by excessive reliance on fellows to fulfill**  
1375 **non-physician service obligations.**  
1376  
1377 ~~VI.A.4.b).(1)~~                   ~~Fellows' service responsibilities must be limited to patients~~  
1378 ~~for whom the teaching service has diagnostic and~~  
1379 ~~therapeutic responsibility.~~  
1380  
1381 **VI.A.5.**                   **The program director and institution must ensure a culture of**  
1382 **professionalism that supports patient safety and personal**  
1383 **responsibility. Fellows and faculty members must demonstrate an**  
1384 **understanding and acceptance of their personal role in the**  
1385 **following:**  
1386  
1387 **VI.A.5.a)**                   **assurance of the safety and welfare of patients entrusted to**  
1388 **their care;**  
1389  
1390 **VI.A.5.b)**                   **provision of patient- and family-centered care;**  
1391  
1392 **VI.A.5.c)**                   **assurance of their fitness for duty;**  
1393  
1394 **VI.A.5.d)**                   **management of their time before, during, and after clinical**  
1395 **assignments;**  
1396  
1397 **VI.A.5.e)**                   **recognition of impairment, including illness and fatigue, in**  
1398 **themselves and in their peers;**  
1399  
1400 **VI.A.5.f)**                   **attention to lifelong learning;**  
1401  
1402 **VI.A.5.g)**                   **the monitoring of their patient care performance improvement**  
1403 **indicators; and,**  
1404  
1405 **VI.A.5.h)**                   **honest and accurate reporting of duty hours, patient**  
1406 **outcomes, and clinical experience data.**  
1407  
1408 **VI.A.6.**                   **All fellows and faculty members must demonstrate responsiveness**  
1409 **to patient needs that supersedes self-interest. Physicians must**  
1410 **recognize that under certain circumstances, the best interests of the**  
1411 **patient may be served by transitioning that patient's care to another**  
1412 **qualified and rested provider.**  
1413  
1414 **VI.B.**                   **Transitions of Care**  
1415  
1416 **VI.B.1.**                   **Programs must design clinical assignments to minimize the number**

- 1417 of transitions in patient care.
- 1418
- 1419 **VI.B.2.** Sponsoring institutions and programs must ensure and monitor
- 1420 effective, structured hand-over processes to facilitate both
- 1421 continuity of care and patient safety.
- 1422
- 1423 **VI.B.3.** Programs must ensure that fellows are competent in communicating
- 1424 with team members in the hand-over process.
- 1425
- 1426 **VI.B.4.** The sponsoring institution must ensure the availability of schedules
- 1427 that inform all members of the health care team of attending
- 1428 physicians and fellows currently responsible for each patient's care.
- 1429
- 1430 **VI.C.** Alertness Management/Fatigue Mitigation
- 1431
- 1432 **VI.C.1.** The program must:
- 1433
- 1434 **VI.C.1.a)** educate all faculty members and fellows to recognize the
- 1435 signs of fatigue and sleep deprivation;
- 1436
- 1437 **VI.C.1.b)** educate all faculty members and fellows in alertness
- 1438 management and fatigue mitigation processes; and,
- 1439
- 1440 **VI.C.1.c)** adopt fatigue mitigation processes to manage the potential
- 1441 negative effects of fatigue on patient care and learning, such
- 1442 as naps or back-up call schedules.
- 1443
- 1444 **VI.C.2.** Each program must have a process to ensure continuity of patient
- 1445 care in the event that a fellow may be unable to perform his/her
- 1446 patient care duties.
- 1447
- 1448 **VI.C.3.** The sponsoring institution must provide adequate sleep facilities
- 1449 and/or safe transportation options for fellows who may be too
- 1450 fatigued to safely return home.
- 1451
- 1452 **VI.D.** Supervision of Fellows
- 1453
- 1454 **VI.D.1.** In the clinical learning environment, each patient must have an
- 1455 identifiable, appropriately-credentialed and privileged attending
- 1456 physician (or licensed independent practitioner as approved by each
- 1457 Review Committee) who is ultimately responsible for that patient's
- 1458 care.
- 1459
- 1460 **VI.D.1.a)** This information should be available to fellows, faculty
- 1461 members, and patients.
- 1462
- 1463 **VI.D.1.b)** Fellows and faculty members should inform patients of their
- 1464 respective roles in each patient's care.
- 1465
- 1466 **VI.D.2.** The program must demonstrate that the appropriate level of

1467 supervision is in place for all fellows who care for patients.  
1468  
1469 Supervision may be exercised through a variety of methods. Some  
1470 activities require the physical presence of the supervising faculty  
1471 member. For many aspects of patient care, the supervising  
1472 physician may be a more advanced resident or fellow. Other  
1473 portions of care provided by the fellow can be adequately  
1474 supervised by the immediate availability of the supervising faculty  
1475 member or resident physician, either in the institution, or by means  
1476 of telephonic and/or electronic modalities. In some circumstances,  
1477 supervision may include post-hoc review of fellow-delivered care  
1478 with feedback as to the appropriateness of that care.  
1479

1480 **VI.D.3. Levels of Supervision**

1481  
1482 To ensure oversight of fellow supervision and graded authority and  
1483 responsibility, the program must use the following classification of  
1484 supervision:  
1485

1486 **VI.D.3.a) Direct Supervision – the supervising physician is physically**  
1487 **present with the fellow and patient.**

1488  
1489 **VI.D.3.b) Indirect Supervision:**

1490  
1491 **VI.D.3.b).(1) with direct supervision immediately available – the**  
1492 **supervising physician is physically within the hospital**  
1493 **or other site of patient care, and is immediately**  
1494 **available to provide Direct Supervision.**

1495  
1496 **VI.D.3.b).(2) with direct supervision available – the supervising**  
1497 **physician is not physically present within the hospital**  
1498 **or other site of patient care, but is immediately**  
1499 **available by means of telephonic and/or electronic**  
1500 **modalities, and is available to provide Direct**  
1501 **Supervision.**

1502  
1503 **VI.D.3.c) Oversight – the supervising physician is available to provide**  
1504 **review of procedures/encounters with feedback provided**  
1505 **after care is delivered.**

1506  
1507 **VI.D.4. The privilege of progressive authority and responsibility, conditional**  
1508 **independence, and a supervisory role in patient care delegated to**  
1509 **each fellow must be assigned by the program director and faculty**  
1510 **members.**

1511  
1512 **VI.D.4.a) The program director must evaluate each fellow’s abilities**  
1513 **based on specific criteria. When available, evaluation should**  
1514 **be guided by specific national standards-based criteria.**

1515  
1516 **VI.D.4.b) Faculty members functioning as supervising physicians**

1517 should delegate portions of care to fellows, based on the  
1518 needs of the patient and the skills of the fellows.  
1519

1520 **VI.D.4.c)** Senior residents or fellows should serve in a supervisory role  
1521 of junior residents in recognition of their progress toward  
1522 independence, based on the needs of each patient and the  
1523 skills of the individual resident or fellow.  
1524

1525 **VI.D.5.** Programs must set guidelines for circumstances and events in  
1526 which fellows must communicate with appropriate supervising  
1527 faculty members, such as the transfer of a patient to an intensive  
1528 care unit, or end-of-life decisions.  
1529

1530 **VI.D.5.a)** Each fellow must know the limits of his/her scope of  
1531 authority, and the circumstances under which he/she is  
1532 permitted to act with conditional independence.  
1533

1534 **VI.D.5.a).(1)** In particular, PGY-1 residents should be supervised  
1535 either directly or indirectly with direct supervision  
1536 immediately available.  
1537

1538 **VI.D.6.** Faculty supervision assignments should be of sufficient duration to  
1539 assess the knowledge and skills of each fellow and delegate to  
1540 him/her the appropriate level of patient care authority and  
1541 responsibility.  
1542

1543 **VI.E.** **Clinical Responsibilities**

1544  
1545 The clinical responsibilities for each fellow must be based on PGY-level,  
1546 patient safety, fellow education, severity and complexity of patient  
1547 illness/condition and available support services.  
1548

1549 **VI.F.** **Teamwork**

1550  
1551 Fellows must care for patients in an environment that maximizes effective  
1552 communication. This must include the opportunity to work as a member of  
1553 effective interprofessional teams that are appropriate to the delivery of care  
1554 in the specialty.  
1555

1556 **VI.G.** **Fellow Duty Hours**

1557

1558 **VI.G.1.** **Maximum Hours of Work per Week**

1559  
1560 Duty hours must be limited to 80 hours per week, averaged over a  
1561 four-week period, inclusive of all in-house call activities and all  
1562 moonlighting.  
1563

1564 **VI.G.1.a)** **Duty Hour Exceptions**

1565  
1566 A Review Committee may grant exceptions for up to 10% or a

1567 maximum of 88 hours to individual programs based on a  
1568 sound educational rationale.  
1569  
1570 *The Review Committee for Internal Medicine will not consider*  
1571 *requests for exceptions to the 80-hour limit to the fellows' work*  
1572 *week.*  
1573  
1574 **VI.G.1.a).(1)** In preparing a request for an exception the program  
1575 director must follow the duty hour exception policy  
1576 from the ACGME Manual on Policies and Procedures.  
1577  
1578 **VI.G.1.a).(2)** Prior to submitting the request to the Review  
1579 Committee, the program director must obtain approval  
1580 of the institution's GMEC and DIO.  
1581  
1582 **VI.G.2.** Moonlighting  
1583  
1584 **VI.G.2.a)** Moonlighting must not interfere with the ability of the fellow  
1585 to achieve the goals and objectives of the educational  
1586 program.  
1587  
1588 **VI.G.2.b)** Time spent by fellows in Internal and External Moonlighting  
1589 (as defined in the ACGME Glossary of Terms) must be  
1590 counted towards the 80-hour Maximum Weekly Hour Limit.  
1591  
1592 **VI.G.2.c)** PGY-1 residents are not permitted to moonlight.  
1593  
1594 **VI.G.3.** Mandatory Time Free of Duty  
1595  
1596 Fellows must be scheduled for a minimum of one day free of duty  
1597 every week (when averaged over four weeks). At-home call cannot  
1598 be assigned on these free days.  
1599  
1600 **VI.G.4.** Maximum Duty Period Length  
1601  
1602 **VI.G.4.a)** Duty periods of PGY-1 residents must not exceed 16 hours in  
1603 duration.  
1604  
1605 **VI.G.4.b)** Duty periods of PGY-2 residents and above may be  
1606 scheduled to a maximum of 24 hours of continuous duty in  
1607 the hospital. Programs must encourage fellows to use  
1608 alertness management strategies in the context of patient  
1609 care responsibilities. Strategic napping, especially after 16  
1610 hours of continuous duty and between the hours of 10:00  
1611 p.m. and 8:00 a.m., is strongly suggested.  
1612  
1613 **VI.G.4.b).(1)** It is essential for patient safety and fellow education  
1614 that effective transitions in care occur. Fellows may be  
1615 allowed to remain on-site in order to accomplish these  
1616 tasks; however, this period of time must be no longer

1617 than an additional four hours.

1618

1619 **VI.G.4.b).(2)** **Fellows must not be assigned additional clinical**

1620 **responsibilities after 24 hours of continuous in-house**

1621 **duty.**

1622

1623 **VI.G.4.b).(3)** **In unusual circumstances, fellows, on their own**

1624 **initiative, may remain beyond their scheduled period**

1625 **of duty to continue to provide care to a single patient.**

1626 **Justifications for such extensions of duty are limited**

1627 **to reasons of required continuity for a severely ill or**

1628 **unstable patient, academic importance of the events**

1629 **transpiring, or humanistic attention to the needs of a**

1630 **patient or family.**

1631

1632 **VI.G.4.b).(3).(a)** **Under those circumstances, the fellow must:**

1633

1634 **VI.G.4.b).(3).(a).(i)** **appropriately hand over the care of all**

1635 **other patients to the team responsible**

1636 **for their continuing care; and,**

1637

1638 **VI.G.4.b).(3).(a).(ii)** **document the reasons for remaining to**

1639 **care for the patient in question and**

1640 **submit that documentation in every**

1641 **circumstance to the program director.**

1642

1643 **VI.G.4.b).(3).(b)** **The program director must review each**

1644 **submission of additional service, and track**

1645 **both individual fellow and program-wide**

1646 **episodes of additional duty.**

1647

1648 **VI.G.5. Minimum Time Off between Scheduled Duty Periods**

1649

1650 **VI.G.5.a)** **PGY-1 residents should have 10 hours, and must have eight**

1651 **hours, free of duty between scheduled duty periods.**

1652

1653 **VI.G.5.b)** **Intermediate-level residents have 10 hours free of duty, and**

1654 **must have eight hours between scheduled duty periods. They**

1655 **must have at least 14 hours free of duty after 24 hours of in-**

1656 **house duty.**

1657

1658 *Internal medicine subspecialty fellows are considered to be in the*

1659 *final years of education.*

1660

1661 **VI.G.5.c)** **Residents in the final years of education be prepared to enter**

1662 **the unsupervised practice of medicine and care for patients**

1663 **over irregular or extended periods.**

1664

1665 *Internal medicine subspecialty fellows are considered to be in the*

1666 *final years of education.*

1667  
1668 **VI.G.5.c).(1)** This preparation must occur within the context of the  
1669 80-hour, maximum duty period length, and one-day-  
1670 off-in-seven standards. While it is desirable that  
1671 fellows in their final years of education have eight  
1672 hours free of duty between scheduled duty periods,  
1673 there may be circumstances when these fellows must  
1674 stay on duty to care for their patients or return to the  
1675 hospital with fewer than eight hours free of duty.  
1676  
1677 **VI.G.5.c).(1).(a)** Circumstances of return-to-hospital activities  
1678 with fewer than eight hours away from the  
1679 hospital by fellows in their final years of  
1680 education must be monitored by the program  
1681 director.  
1682  
1683 **VI.G.5.c).(1).(b)** In unusual circumstances, fellows may remain  
1684 beyond their scheduled period of duty or return  
1685 after their scheduled period of duty to provide care  
1686 to a single patient. Justifications for such  
1687 extensions of duty are limited to reasons of  
1688 required continuity of care for a severely ill or  
1689 unstable patient, academic importance of the  
1690 events transpiring, or humanistic attention to the  
1691 needs of the patient or family. Such episodes  
1692 should be rare, must be of the fellows' own  
1693 initiative, and need not initiate a new 'off-duty  
1694 period' nor require a change in the scheduled 'off-  
1695 duty period.'  
1696  
1697 **VI.G.5.c).(1).(c)** Under such circumstances, the fellow must  
1698 appropriately hand over care of all other patients to  
1699 the team responsible for their continuing care, and  
1700 document the reasons for remaining or returning to  
1701 care for the patient in question and submit that  
1702 documentation to the program director.  
1703  
1704 **VI.G.5.c).(1).(d)** The program director must review each submission  
1705 of additional service and track both individual  
1706 fellows' and program-wide episodes of additional  
1707 duty.  
1708  
1709 **VI.G.6.** **Maximum Frequency of In-House Night Float**  
1710  
1711 **Fellows must not be scheduled for more than six consecutive nights**  
1712 **of night float.**  
1713  
1714 **VI.G.7.** **Maximum In-House On-Call Frequency**  
1715  
1716 **PGY-2 residents and above must be scheduled for in-house call no**

1717 more frequently than every-third-night (when averaged over a four-  
1718 week period).  
1719

1720 VI.G.7.a) *Internal Medicine ~~residency programs are~~ fellowships must not*  
1721 *allowed to average in-house call over a four-week period.*  
1722

1723  
1724 **VI.G.8. At-Home Call**  
1725

1726 **VI.G.8.a)** Time spent in the hospital by fellows on at-home call must  
1727 count towards the 80-hour maximum weekly hour limit. The  
1728 frequency of at-home call is not subject to the every-third-  
1729 night limitation, but must satisfy the requirement for one-day-  
1730 in-seven free of duty, when averaged over four weeks.  
1731

1732 **VI.G.8.a).(1)** At-home call must not be so frequent or taxing as to  
1733 preclude rest or reasonable personal time for each  
1734 fellow.  
1735

1736 **VI.G.8.b)** Fellows are permitted to return to the hospital while on at-  
1737 home call to care for new or established patients. Each  
1738 episode of this type of care, while it must be included in the  
1739 80-hour weekly maximum, will not initiate a new “off-duty  
1740 period”.  
1741

1742 **VII. Innovative Projects**  
1743

1744 Requests for innovative projects that may deviate from the institutional, common  
1745 and/or specialty specific program requirements must be approved in advance by  
1746 the Review Committee. In preparing requests, the program director must follow  
1747 Procedures for Approving Proposals for Innovative Projects located in the ACGME  
1748 Manual on Policies and Procedures. Once a Review Committee approves a  
1749 project, the sponsoring institution and program are jointly responsible for the  
1750 quality of education offered to fellows for the duration of such a project.  
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1754 ACGME Approved: February 5, 2011      Effective: July 1, 2012