

## General Program Requirements for Fellowship Education in the Subspecialties of Internal Medicine

### [Common Program Requirements = Bold/]

#### **I. Introduction**

##### **A. Definition and Scope of Specialty**

1. Subspecialty training in internal medicine is a voluntary component in the continuum of medical education. Subspecialty training should take place after satisfactory completion of an accredited program in internal medicine.
2. When averaged over any 5-year period, a minimum of 75% of fellows in each subspecialty training program must be graduates of a training program in internal medicine which is accredited by the Accreditation Council for Graduate Medical Education (ACGME); fellows not trained in a program accredited by the ACGME must have at least 3 years of internal medicine training prior to beginning a fellowship. The program director must inform non-ACGME trained applicants before their appointment in writing of the American Board of Internal Medicine (ABIM) policies and procedures that may affect their eligibility for ABIM certification. (N.B.: Fellows in the subspecialty of geriatric medicine may be graduates of an ACGME-accredited family practice training program.)
3. Subspecialty programs must provide advanced training to allow fellows to acquire competency in the subspecialty with sufficient expertise to act as a consultant.

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

1. To be eligible for accreditation, a subspecialty program must function as an integral part of an accredited residency program in internal medicine.
2. To ensure compliance with the ACGME accreditation standards, there must be a reporting relationship from the program director of the subspecialty program to the program director of the parent internal medicine residency program.
3. The discipline must be one for which a certificate or a certificate of added qualifications is offered by the ABIM. (N.B.: The term *subspecialty* is used throughout this document for both types of training programs.)

##### **C. Educational Standards**

Fellowship training is primarily an educational experience. These program requirements define the minimum standards and outcomes for fellowship education in the subspecialties of internal medicine. They balance didactic instruction and education through direct patient care.

## **II. Institutions**

### **A. Sponsoring Institution**

**One sponsoring institution must assume the ultimate responsibility for the program as described in the Institutional Requirements; and this responsibility extends to assignments of fellows at all participating institutions.**

1. The sponsoring institution must demonstrate a commitment to education and research sufficient to support the fellowship program.
2. The sponsoring institution must establish the internal medicine subspecialty fellowship within a department of internal medicine or within an administrative unit whose primary mission is the advancement of internal medicine education and patient care.
3. The sponsoring institution must provide fellows compensation and benefits, faculty, facilities, and resources for education, clinical care, and research required for accreditation.
4. The sponsoring institution must assure that adequate salary support is provided to the program director for the administrative activities of the internal medicine subspecialty program. The program director must not be required to generate clinical or other income to provide this administrative support. It is suggested that this support be 25%-50% of the program director's salary, depending upon the size of the program. (See Section III.A.4.f )
5. The sponsoring institution must notify the RRC within 60 days of changes in institutional governance, affiliation, or resources that affect the educational program.
6. Graduate education in the subspecialties of internal medicine requires a major commitment to education by the sponsoring institution. Evidence of such a commitment includes each of the following:
  - a) The minimum number of fellowship positions supported by the institution in each training program must not be fewer than the number of accredited training years in the program.
  - b) The institution must assure significant research in each subspecialty for which it sponsors a training program.

### **B. Participating Institutions**

Participating institutions include both the Primary Training Site and other training sites. The Primary Training Site is defined as the health-care facility that provides the required training resources, should be the location of the program director's major activity, the location where the fellows spend the majority of their clinical training time, and the primary location of the core program in internal medicine.

1. **Assignment to an institution must be based on a clear educational**

rationale, integral to the program curriculum, with clearly-stated activities and objectives. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.

2. **Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:**
  - a) **identity the faculty who will assume both educational and supervisory responsibilities for fellows;**
  - b) **specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document;**
  - c) **specify the duration and content of the educational experience at the participating institution, the financial agreements, and the details for insurance and benefits; and**
  - d) **state the policies and procedures that will govern fellow education during the assignment.**
3. The Residency Review Committee (RRC) must give prior approval for participation by any institution providing 3 months or more of training in a 12 or 24 month program; or 6 months or more of training in a 36 month program.
4. Assignments at participating institutions must be of sufficient length to ensure a quality educational experience, and should provide sufficient opportunity for continuity of care. Although the number of participating institutions may vary with the various specialties' needs, all participating institutions must demonstrate the ability to promote the program goals and educational and peer activities. Exceptions must be justified and prior-approved by the RRC.

### **III. Program Personnel and Resources**

#### **A. Program Director**

1. **There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either program director or department chair, the program director should promptly notify the executive director of the RRC through the Web Accreditation Data System of the ACGME.**
2. **The program director, together with the faculty, is responsible for the general administration of the program, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an appropriate continuity of leadership.**
3. **Qualifications of the program director are as follows:**
  - a) **The program director must possess the requisite subspecialty**

expertise, as well as documented educational and administrative abilities.

- b) **The program director must be certified in the subspecialty by the American Board of Internal Medicine, or possess qualifications judged to be acceptable by the RRC.**
- c) **The program director must be appointed in good standing and based at the primary teaching site** ( i.e., his or her home office must be at either the sponsoring institution, or the site where fellows receive the majority of their training). The program director must be responsible to the sponsoring organization.
- d) The program director must have at least 5 years of participation as an active faculty member in an internal medicine subspecialty fellowship program accredited by the ACGME.

**4. Responsibilities of the program director are as follows:**

- a) **The program director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and monitoring appropriate fellows supervision at all participating institutions.**
- b) **The program director is responsible for preparing an accurate statistical and narrative description of the program as requested by the RRC, as well as updating annually both program and fellows records through the ACGME's Accreditation Data System.**
- c) **The program director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.**
- d) **The program director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the fellows. Such changes, for example, include:**
  - (1) **the addition or deletion of a participating institution;**
  - (2) **a change in the format of the educational program;**
  - (3) **a change in the approved fellows complement** ( i.e., any temporary or permanent increase in the total number of enrolled fellows).

**On review of a proposal for any such major change in a program,**

**the RRC may determine that a site visit is necessary.**

- e) The program director is responsible for monitoring fellow stress (including mental or emotional conditions inhibiting performance or learning) and drug- or alcohol-related dysfunction. Both the program director and faculty should be sensitive to the need for timely provision of confidential counseling and psychological support services to fellows. Situations that demand excessive service or that consistently produce undesirable stress on fellows must be evaluated and modified.
- f) The program director must dedicate an average of 20 hours per week of his or her professional effort to the internal medicine subspecialty educational program, with sufficient time for administration of the program, and should receive institutional support for that administrative time (see Section II A 4 above).
- g) The program director must participate in academic societies and in educational programs designed to enhance his or her educational and administrative skills.
- h) The program director must implement a program of continuous quality improvement in medical education for the faculty, especially as it pertains to the teaching and evaluation of the ACGME Competencies (as outlined in Section V D of this document).

**B. Faculty**

1. **At each participating institution, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately all fellows in the program.**
2. **The faculty, furthermore, must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must demonstrate a strong interest in the education of fellows, and must support the goals and objectives of the educational program of which they are a member.**
3. **Qualifications of the physician faculty are as follows:**
  - a) **The physician faculty must possess the requisite subspecialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.**
  - b) **The physician faculty must be certified in the subspecialty by the American Board of Internal Medicine, or possess qualifications judged to be acceptable by the RRC.**
  - c) **The physician faculty must be appointed in good standing to the**

**staff of an institution participating in the program.**

- d) The physician faculty must be licensed to practice medicine in the state where the sponsoring institution is located or the major teaching activity occurs. (N.B.: Certain federal programs are exempted.)
- e) The physician faculty must meet professional standards of ethical behavior.

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

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

**Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for fellows involved in research such as research design and statistical analysis); and the provision of support for fellows' participation, as appropriate, in scholarly activities.**

- d) The majority of faculty must be involved in scholarship as defined in Section III.B.4.a), b), or c) above.
- e) The majority of key clinical faculty must demonstrate evidence of productivity in the scholarship as defined in Section III.B.4.a) or b) above.
- f) At least one faculty member must be active in the scholarship of discovery as defined in Section III.B.4.a) above.

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

- a) **Nonphysician faculty must be appropriately qualified in their field.**
- b) **Nonphysician faculty must possess appropriate institutional appointments.**

**6. Key Clinical Faculty**

In addition to the program director, each program must have two key clinical

faculty (KCF). KCF are attending physicians who dedicate, on average, 10 hours per week throughout the year to the training program. For programs with an approved compliment of more than five fellows during the accredited portion of the training program, a ratio of KCF to fellows of at least 1:1.5 must be maintained. (N.B.: The required number of KCF may vary by subspecialty.)

- a) Qualifications of the key clinical faculty are as follows:
    - (1) Key clinical faculty must be active clinicians with broad knowledge of, experience with, and commitment to the internal medicine subspecialty as a discipline.
    - (2) Key clinical faculty must **be certified in the subspecialty by the American Board of Internal Medicine or possess qualifications judged by the RRC to be acceptable.**
  - b) Responsibilities for the key clinical faculty are as follows:

In addition to the responsibilities of all individual faculty, the key clinical faculty, together with the program director, are responsible for the planning, implementation, monitoring and evaluation of the fellow's clinical and research training.
7. All clinical faculty members should participate in prescribed faculty development programs designed to enhance the effectiveness of their teaching.

**C. Other Program Personnel**

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

**D. Resources**

1. **The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available.**
2. Fellows must have clinical experiences in efficient, effective ambulatory and inpatient care settings.
  - a) Space and equipment

There must be space and equipment for the educational program, including meeting rooms, classrooms, examination rooms, computers, visual and other educational aids, and work/study space.
  - b) Facilities
    - (1) Fellows must have lounge and food facilities during assigned duty hours.
    - (2) When fellows are assigned night duty in the hospital or are called in from home, they must be provided with on-call facilities that are convenient and that afford privacy, safety,

and a restful environment with a secure space for their belongings.

3. Medical Records

Clinical records that document both inpatient and ambulatory care must be readily available at all times. (See Institutional Requirements, Section II.D.3.d) )

4. Medical Reference Material

Fellows must have access at all times and in each participating institution to:

a) reference material (i.e., textbooks and journals) either print or electronic

b) a computerized literature search system and electronic medical databases.

5. Patient Population

a) The inpatient and ambulatory care population must provide experience with patients whose illnesses are encompassed by, and help to define, the subspecialty.

b) There must be patients of both sexes, with a broad age range, including geriatric patients.

c) A sufficient number of patients must be available to ensure adequate inpatient and ambulatory experience for each subspecialty fellows without diluting the experience of the fellows in the general internal medicine residency program.

6. Pathology Material

a) All deaths of patients who received care by fellows must be reviewed and autopsies performed whenever possible.

b) Fellows must receive autopsy reports after autopsies are completed on their patients.

7. Support Services

a) Administrative support must include adequate secretarial and administrative staff, and technology to support the program director.

b) Inpatient clinical support services must be available on a 24-hour basis to meet reasonable and expected demands, including intravenous services, phlebotomy services, messenger/transporter services, and laboratory and radiologic information retrieval systems that allow prompt access to results.

c) Consultations from other clinical services in the hospital must be available in a timely manner. All consultations should be performed by or under the supervision of a qualified specialist.

**IV. Fellows Appointment**

**A. Eligibility Criteria**

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

**B. Number of Fellows**

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

**C. Fellows Transfer**

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

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

**The appointment of fellows, other specialty fellows, or students or trainees from programs not accredited by the ACGME must not dilute or detract from the educational opportunities of internal medicine fellows.**

**E. Fellows Responsibilities and Professional Relationships**

Fellows must have clearly defined written lines of responsibility for all clinical experiences.

**V. Program Curriculum**

**A. Program Design**

**1. Format**

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

**2. Goals and Objectives**

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

- a) should include the educational purpose; teaching methods; the mix of diseases, patient characteristics, and types of clinical encounters,

procedures, and services; reading lists, pathological material, and other educational resources to be used; and the method for evaluation of fellows competence;

- b) must define the level of fellows' supervision by faculty members in all patient-care activities; and
- c) should be reviewed and revised at least every 3 years by faculty members and fellows to keep goals and objectives current and relevant.

**B. Specialty Curriculum**

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

**C. Fellows Scholarly Activities and Research**

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

2. Participation in an active research program is an essential component for fellows enrolled in subspecialty fellowship training programs of 24 months or greater duration.

- a) The program must ensure a meaningful, supervised research experience with appropriate protected time for each fellow--either in blocks or concurrent with clinical rotations-- while maintaining the essential clinical experience.
- b) Fellows must be advised and supervised by qualified faculty members in the conduct of research.
- c) Fellows must learn the standards of ethical conduct of research, design and interpretation of research studies, responsible use of informed consent, research methodology, and interpretation of data.
- d) The majority of fellows must demonstrate evidence of recent research productivity through:
  - (1) publication (manuscripts or abstracts) in peer-reviewed journals, or
  - (2) abstracts presented at national specialty meetings(N.B.: Training programs in critical care medicine, internal medicine-geriatric medicine, and internal medicine-sports medicine are exempt from this requirement.)

**D. ACGME Competencies**

**The fellowship program must require its fellows to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must**

**define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their fellows to demonstrate the following:**

- 1. patient care that is compassionate, appropriate, and effective for the treatment of health programs and the promotion of health;**
- 2. medical knowledge about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;**
- 3. practice-based learning and improvement that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;**
- 4. interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;**
- 5. professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;**
- 6. systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.**

**E. Didactics**

1. Inpatient and Consultation Teaching
  - a) Teaching and management rounds are usually combined in subspecialty training programs. These rounds must be patient-based sessions in which current cases are presented as a basis for discussion of such points as interpretation of clinical data, pathophysiology, differential diagnosis, specific management of the patient, the appropriate use of technology, the incorporation of evidence and patient values in clinical decision making, and disease prevention.
  - b) The total teaching time spent in combined management and teaching rounds must exceed by a minimum of 5 hours per week the time required to supervise the care of patients.
2. Conferences and Seminars
  - a) Conferences must be conducted regularly as scheduled and must be attended by faculty and fellows. At a minimum, these must include:
    - (1) at least one clinical conference weekly;
    - (2) one literature review conference (journal club) monthly;

- (3) one research conference monthly; and
  - (4) at least one core curriculum conference weekly, when averaged over 1 year.
    - (a) The core curriculum conference series must include the basic sciences relevant to the subspecialty.
    - (b) The core curriculum conference series must cover the major clinical topics in the subspecialty.
    - (c) The core curriculum conference series must be repeated frequently enough, or be made available for review on tape or electronically, to afford each fellow an opportunity to attend or review most of the core conference topics.
  - b) Fellows must participate in formal review of gross and microscopic pathological material from patients who have been under their care.
  - c) Fellows must participate in planning and in conducting conferences.
3. Interdisciplinary Topics
- a) Fellows should become proficient in the critical assessment of medical literature, medical informatics, clinical epidemiology, and biostatistics.
  - b) Educational experiences should include instruction in the following:
    - (1) clinical ethics;
    - (2) medical genetics;
    - (3) quality assessment;
    - (4) quality improvement;
    - (5) patient safety;
    - (6) risk management;
    - (7) preventive medicine;
    - (8) pain management;
    - (9) end-of-life care; and
    - (10) physician impairment.

**F. Clinical**

**1. Ambulatory medicine**

- a) There must be on-site faculty whose primary responsibilities include the supervision and teaching of fellows.
- b) Fellows must be able to obtain appropriate and timely consultation from other specialties for their ambulatory patients.
- c) There should be services available from other health-care professionals such as nurses, social workers, language interpreters, and dietitians.

**2. Experience with continuity ambulatory patients**

- a) Fellows must have a continuity ambulatory clinic experience 1/2-day each week to develop a continuous healing relationship with patients for whom they provide subspecialty care. This continuity experience should expose fellows to the breadth and depth of the subspecialty. (N.B.: This continuity requirement may vary by subspecialty.) This may be accomplished by either:
  - (1) A single continuity clinic for the length of the accredited fellowship, or
  - (2) Blocks of at least 6 months duration for the length of the accredited fellowship.
- b) Each fellow should, on average, be responsible for four to eight patients during each 1/2-day session.
- c) Over the course of accredited training, each fellow's panel of patients must include at least 25% of patients from each gender.
- d) Each fellow's clinical experiences with ambulatory patients must provide an opportunity to observe and to learn the course of disease.
- e) The continuing patient-care experience should not be interrupted by more than 1 month, excluding a fellow's vacation.
- f) During the continuity experience, arrangements should be made to minimize interruptions of the experience by fellows' duties on inpatient and consultation services.
- g) It is suggested that fellows be informed of the status of their continuity patients when they are hospitalized so fellows may make appropriate arrangements to maintain continuity of care.

### **3. Procedures**

- a) Fellows must develop a comprehensive understanding of indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline.
- b) Fellows must acquire knowledge of and skill in educating patients about the rationale, technique, and complications of procedures, and in obtaining procedure-specific informed consent.
- c) Faculty must supervise the procedures performed by each fellow until proficiency has been acquired and documented by the program director
- d) Each program must:
  - (1) identify key procedures;
  - (2) define a standard for proficiency;

- (3) document achievement of proficiency; and
- (4) assure that fellows log all key procedures performed.

## **VI. Fellows Duty Hours and the Work Environment**

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

### **A. Supervision of Fellows**

- 1. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of fellows at all times. Fellows must be provided with rapid, reliable systems for communicating with supervising faculty.**
- 2. Faculty schedules must be structured to provide fellows with continuous supervision and consultation.**
- 3. Faculty and fellows must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.**

### **B. Duty Hours**

- 1. Duty hours are defined as all clinical and academic activities related to the fellowship program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in house during call activities, and scheduled activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.**
- 2. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**
- 3. Fellows must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.**
- 4. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.**

### **C. On-Call Activities**

**The objective of on-call activities is to provide fellows with continuity of patient**

**care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day, when fellows are required to be immediately available in the assigned institution.**

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

**D. Moonlighting**

- 1. Because fellowship education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the fellows to achieve the goals and objectives of the educational program.**
- 2. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.**
- 3. Any hours a fellow works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of internal moonlighting.**

**E. Oversight**

- 1. Each program must have written policies and procedures consistent with**

**the Institutional and Program Requirements for fellows duty hours and the working environment. These policies must be distributed to the fellows and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate balance between education and service.**

2. **Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create fellows fatigue sufficient to jeopardize patient care.**

**F. Duty-Hour Exception**

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

**G. Service versus education**

A sponsoring institution must not place excessive reliance on fellows to meet the service needs of the participating training sites.

1. Fellows must not be required to provide routine intravenous, phlebotomy, or messenger/transporter services.
2. Fellows' service responsibilities must be limited to patients for whom the teaching service has diagnostic and therapeutic responsibility.
3. The admission and continuing care of patients by fellows must be limited to those patients on the teaching service.

**H. Grievance Procedures and Due Process**

1. In the event of an adverse annual evaluation, a fellow must be offered an opportunity to address a judgment of academic deficiencies or misconduct before a formally constituted clinical competence committee.
2. There must be a written policy that ensures that academic due process is provided.

**VII. Evaluation**

**A. Fellows**

**1. Formative Evaluation**

**The faculty must evaluate in a timely manner the fellows whom they supervise. In addition, the fellowship program must demonstrate that it has an effective mechanism for assessing fellows performance throughout the program, and for utilizing the results to improve fellows performance.**

- a) **Assessment should include the use of methods that produce an accurate assessment of fellows' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.**
- b) **Assessment should include the regular and timely performance**

**feedback to fellows that includes at least semiannual written evaluations**, and a formal evaluation of knowledge, skills, and professional growth of fellows and required counseling by the program director. **Such evaluations are to be communicated to each fellow in a timely manner, and maintained in a record that is accessible to each fellow.**

- c) Permanent records of both of the evaluation and counseling sessions (and any others that occur) for each fellow must be maintained in the fellow's file, and must be accessible to the fellows and other authorized personnel.
- (1) The record of evaluation should document the fellow's achievement of the competencies using appropriate evaluation methods.
  - (2) The record of evaluation should document that records were maintained by documentation logbook or by an equivalent method to demonstrate that fellows have achieved competence in the performance of invasive procedures. These records must state the indications and complications, and include the names of the supervising physicians. Such records must be of sufficient detail to permit use in future credentialing.
  - (3) The record of evaluation should document that fellows were evaluated in writing, and that their performance was reviewed with them verbally on completion of each rotation period (and at least quarterly for longitudinal assignments).
  - (4) The record of evaluation should document that fellows were evaluated in writing, and that their performance in continuity clinic was reviewed with them verbally on at least a semiannual basis.
- d) **Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, including nurses, to achieve progressive improvements in fellows' competence and performance.**

## 2. **Final (Summative) Evaluation**

**The program director must provide a final evaluation for each fellow who completes the program. The evaluation must include a review of the fellow's performance during the final period of education and should verify that the fellow has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be**

part of the fellow's permanent record maintained by the institution.

**B. Faculty and Rotation Assessment**

1. **The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle, and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. This evaluation must include annual written confidential evaluations by fellows.** Provision must be made for fellows to confidentially provide written evaluations of each teaching attending at the end of a rotation or assignment, and for the evaluations to be reviewed with faculty annually.
2. In addition to evaluation of the effectiveness of teaching of the faculty, fellows must evaluate the effectiveness of the rotation or assignment in achievement of the goals and objectives identified in the curriculum for that rotation or assignment.
3. The results of the evaluations must be used for counseling faculty, for selecting faculty for teaching assignments, and for annual program review (see below).

**C. Program**

1. **Representative program personnel (i.e., at least the program director, representative faculty, and one fellow) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution, and the fellows' annual confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.**
  - a) In addition, the fellows must annually evaluate in writing the effectiveness of the program in achieving the goals and objectives identified in the curriculum. The evaluation should include the utilization of the resources available to the program, the contribution of each institution participating in the program, the financial and administrative support of the program, the volume and variety of patients available to the program for educational purposes, the effectiveness of inpatient and ambulatory teaching, the performance of faculty members, and the quality of supervision of fellows.
2. **The program should use fellow performance and outcome assessment in its**

**evaluation of the educational effectiveness of the fellowship program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the fellowship program.**

- a) At least 80% of those eligible to take an ABIM subspecialty certifying examination upon completion of their training for the most recently 5 year period must have taken an ABIM subspecialty certifying examination.

(Note: Five-year rolling pass rate for first time takers of the ABIM certifying examination will be examined at each program review.)

#### **VIII. Experimentation and Innovation**

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

#### B. Performance Improvement Process

1. The program should identify and participate in at least one ongoing performance improvement (PI) activity which relates to the competencies.
2. The PI activity must involve both fellows and faculty in planning and implementing.
3. The PI activity should result in measurable improvements in patient care or fellowship education.

#### **IX. Board Certification**

Fellows **who plan to seek certification** in the specific subspecialty **by the American Board of Internal Medicine should communicate with the office of the board regarding the full requirements for certification.**

#### **X. Subspecialty Specific Program Requirements**

The Program Requirements for training programs in a specific subspecialty may exceed the minimum requirements set forth above.

## **Program Requirements for Fellowship Education in Infectious Diseases**

*For sections I. through X., see Program Requirements for Fellowship Education in the Subspecialties of Internal Medicine.*

### **XI. Educational Program**

- A. A subspecialty educational program in infectious diseases must be organized to provide training and supervised experience at a level sufficient for the fellow to acquire the competency of a specialist in the field.
- B. The training program must be 2 years in duration.
- C. A minimum of 12 months must be devoted to clinical experiences.
- D. Ambulatory medicine experience  
Continuity ambulatory care experience of 24 months must be included in the training program. During their ambulatory experience, fellows must have training in both consultative services and continuing care in infectious disease, including human immunodeficiency virus (HIV) infection.

### **XII. Faculty**

*See Program Requirements for Fellowship Education in the Subspecialties of Internal Medicine.*

### **XIII. Facilities and Resources**

In addition to the facilities and resources outlined in the Program Requirements for Fellowship Education in the Subspecialties of Internal Medicine, each of the following must be present at the primary training site:

- A. Diagnostic Laboratory Services  
Fellows must have convenient access to a laboratory for clinical microbiology, such that direct and frequent interaction with microbiology laboratory personnel is readily available. (N.B.: This laboratory does not need to be located at the primary training site.)
- B. Imaging  
No additional facilities are required.
- C. Surgery and Pathology  
No additional facilities or services are required.
- D. Other Facilities, Resources, or Support Services
  - 1. Facilities for the isolation of patients with infectious diseases must be available.
  - 2. It is suggested that the training program be conducted in a setting in which training programs in surgery, obstetrics, gynecology, pediatrics, and other medical and surgical specialties and subspecialties are available.

E. Patient Population

*See Program Requirements for Fellowship Education in the Subspecialties of Internal Medicine.*

XIV. Specific Program Content

A. Clinical Experience

1. Clinical experience must include opportunities to manage adult and geriatric patients with a wide variety of infectious diseases in both an inpatient and ambulatory basis. Such opportunities must encompass longitudinal experiences in a continuum of care in order to observe the course of illness and the effects of therapy. Therapeutic modalities should include management of antibiotic administration in settings such as the acute care hospital, the office, and in conjunction with the non-acute care facility or home-care services.
2. Experience with pediatric infectious diseases is suggested.

B. Technical and Other Skills

1. Fellows must receive formal instruction and gain practical experience in hospital epidemiology and infection control. This can be accomplished by didactic or practical experience, as offered through organized coursework, service on an infection control committee, or by an assigned rotation on a hospital epidemiology service.
2. Fellows must receive formal instruction and gain practical experience in clinical microbiology.
3. Fellows must have clinical experience and demonstrate competence in the evaluation and management of infections in patients with major impairments of host defense.
  - a) The teaching services on which fellows work must provide an average of at least 50 consultations per fellow during the period in which fellows are rotating on these services for their clinical training.
  - b) This experience includes, but is not limited to:
    - (1) patients who are neutropenic;
    - (2) patients with leukemia, lymphoma or other malignancies;
    - (3) patients following solid organ or bone marrow transplantation; and
    - (4) patients with HIV/AIDS or patients immunocompromised by other diseases or medical therapies.
  - c) Documentation of the number of consultations above may be completed

for the teaching service overall rather than per fellow, if these numbers are available for the service; in this case, individual fellow logs are not necessary. Otherwise, fellows should document the number of consultations by an individual log.

4. Fellows must have formal instruction or clinical experience and must demonstrate competence in the evaluation and management of the following disorders:

- a) infections of the reproductive organs;
- b) infections in solid organ transplant patients;
- c) infections in bone marrow transplant recipients;
- d) sexually transmitted diseases;
- e) viral hepatitis, including hepatitis B and C; and
- f) infections in travelers.

5. Consultation Experience

The inpatient teaching services on which fellows work must provide an average of at least 250 consultations per fellow during the period the fellows are rotating on these services for their clinical training. These consultations must be provided in a variety of clinical settings, including:

- a) Inpatient General Medical and Surgical Wards, and Intensive Care Units

In these settings, fellows must have clinical experience and must demonstrate competence in the evaluation and management of patients with the following disorders:

- (1) pleuropulmonary infections;
- (2) infections and other complications in patients with HIV/AIDS;
- (3) cardiovascular infections;
- (4) central nervous system infections;
- (5) gastrointestinal and intra-abdominal infections;
- (6) skin and soft tissue infections;
- (7) bone and joint infections;
- (8) infections of prosthetic devices;
- (9) infections related to trauma;
- (10) sepsis syndromes;
- (11) nosocomial infections; and
- (12) urinary tract infections.

6. Ambulatory Medicine Experience
  - a) Ambulatory training must include longitudinal care (at least 12 months of direct supervision of each patient) of at least 20 patients with HIV infection.
  - b) Direct oversight of the longitudinal care of patients with HIV infection by the fellows must be provided by an experienced HIV physician.
  - c) At a minimum, 25% of patients of either gender must be represented in the fellow's panel of patients. If this gender distribution is not feasible due to the local epidemiology of HIV, then alternative clinical experiences or didactic instruction must be provided.

C. Formal Instruction

1. The training program must provide formal instruction for the fellows in the cognitive aspects of the following:
  - a) mechanisms of action and adverse reactions of antimicrobial agents; antimicrobial and antiviral resistance; drug-drug interactions between antimicrobial agents and other compounds; the appropriate use and management of antimicrobial agents in a variety of clinical settings, including the hospital, ambulatory practice, non acute-care units, and the home;
  - b) methods of determining antimicrobial activity of a drug; techniques to determine concentration of antimicrobial agents in the blood and other body fluids; interpretation of antibiotic levels in blood;
  - c) appropriate procedures for specimen collection relevant to infectious disease, including but not limited to bronchoscopy, thoracentesis, arthrocentesis, lumbar puncture, and aspiration of abscess cavities;
  - d) principles of prophylaxis and immunoprophylaxis to enhance resistance to infection;
  - e) characteristics, use, and complications of antiretroviral agents, mechanisms and clinical significance of viral resistance to antiretroviral agents, and recognition and management of opportunistic infections in patients with HIV/AIDS;
  - f) methods for accessing databases of relevance to the care and management of individuals with infectious diseases; and
  - g) the epidemiology, clinical course, manifestations, diagnosis, treatment and prevention of mycobacterial infections and major parasitic

diseases.

2. Conferences and Seminars

As part of the required conferences and seminars outlined in the Program Requirements for Fellowship Education in the Subspecialties in Internal Medicine, a minimum of 25 hours each year must be devoted to discussion of HIV-related topics.

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