

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Nephrology (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~~ Nephrology fellowships must 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 accredited fellowship~~ The educational program in nephrology must provide ~~be~~**
39 **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. The nephrology fellowship program must function as an integral part of an
54 ACGME-accredited residency program in internal medicine.
55
56 I.A.2. *The sponsoring institution must:*
57
58 I.A.2.a) establish the nephrology 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 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 less than the number of accredited training years in the~~
99 ~~program~~

100
101 **I.B. Participating Sites**
102

103 **I.B.1.** There must be a program letter of agreement (PLA) between the
104 program and each participating site providing a required
105 assignment. The PLA must be renewed at least every five years.

106
107 The PLA should:

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

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

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

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

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

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

129
130 **II.A. Program Director**

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

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

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

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

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

152

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

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

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

304 faculty with documented qualifications to instruct and supervise all
305 fellows at that location.

306
307 The faculty must:

308
309 **II.B.1.a)** devote sufficient time to the educational program to fulfill
310 their supervisory and teaching responsibilities; and to
311 demonstrate a strong interest in the education of fellows;
312 and,

313
314 **II.B.1.b)** administer and maintain an educational environment
315 conducive to educating fellows in each of the ACGME
316 competency areas.

317
318 **II.B.2.** The physician faculty must have current certification in the
319 subspecialty by the American Board of Internal Medicine, or possess
320 qualifications acceptable by the Review Committee.

321
322 **II.B.3.** The physician faculty must possess current medical licensure and
323 appropriate medical staff appointment.

324
325 **II.B.4.** The nonphysician faculty must have appropriate qualifications in
326 their field and hold appropriate institutional appointments.

327
328 **II.B.5.** The faculty must establish and maintain an environment of inquiry
329 and scholarship with an active research component.

330
331 **II.B.5.a)** The faculty must regularly participate in organized clinical
332 discussions, rounds, journal clubs, and conferences.

333
334 **II.B.5.b)** Some members of the faculty should also demonstrate
335 scholarship by one or more of the following:

336
337 **II.B.5.b).(1)** peer-reviewed funding;

338
339 **II.B.5.b).(2)** publication of original research or review articles in
340 peer-reviewed journals or chapters in textbooks;

341
342 **II.B.5.b).(3)** publication or presentation of case reports or clinical
343 series at local, regional, or national professional and
344 scientific society meetings; or,

345
346 **II.B.5.b).(4)** participation in national committees or educational
347 organizations.

348
349 **II.B.5.c)** Faculty should encourage and support fellows in scholarly
350 activities.

351
352 **II.B.6.** *The physician faculty must meet professional standards of ethical*
353 *behavior.*

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

405
406 **The institution and the program must jointly ensure the availability of all**
407 **necessary professional, technical, and clerical personnel for the effective**
408 **administration the program.**

409
410 II.C.1. *There must be services available from other health care professionals,*
411 *including dietitians, language interpreters, nurses, occupational*
412 *therapists, physical therapists, and social workers.*

413
414 II.C.2. There must be a close working relationship with dietary and/or nutrition
415 services and social services, as well as with specialists in pathology,
416 psychiatry, obstetrics and gynecology, radiology, urology, and surgery.

417
418 II.C.3. *There must be ~~ensure the availability of~~ appropriate and timely*
419 *consultation from other specialties.*

420
421 **II.D. Resources**

422
423 **The institution and the program must jointly ensure the availability of**
424 **adequate resources for fellow education, as defined in the specialty**
425 **program requirements.**

426
427 II.D.1. *Space and Equipment*

428
429 *There must be space and equipment for the ~~educational~~ program,*
430 *including meeting rooms, ~~classrooms,~~ examination rooms, computers,*
431 *visual and other educational aids, and work/study space.*

432
433 II.D.2. *Facilities*

434
435 *II.D.2.a) Inpatient and outpatient systems must be in place to prevent*
436 *fellows from performing routine clerical functions, such as*
437 *scheduling tests and appointments, and retrieving records and*
438 *letters.*

439
440 *II.D.2.b) The sponsoring institution must provide the broad range of*
441 *facilities and clinical support services required to provide*
442 *comprehensive care of adult patients. ~~Fellows must have clinical~~*
443 *experiences in efficient, effective ambulatory and inpatient care*
444 *settings.*

445
446 *II.D.2.c) Fellows must have access to a lounge facility during assigned*
447 *duty hours.*

448
449 *II.D.2.d) When fellows are ~~assigned night duty in the hospital,~~ assigned*
450 *night duty, or called in from home, they must be provided with ~~on-~~*
451 *call facilities that are convenient and that afford privacy, safety,*
452 *and a restful environment with a secure space for their*
453 *belongings.*

454
455 II.D.3. *Laboratory and Imaging Services*

- 456
457 II.D.3.a) ~~Each of The~~ following must be ~~present~~ available at the primary
458 ~~training clinical site or affiliated institutions at participating sites:~~
459
460 II.D.3.a).(1) ~~There must be~~ biochemistry and serologic laboratories;
461 and,
462
463 II.D.3.a).(2) ~~Available~~ imaging services, ~~must including~~ ultrasound,
464 computerized tomography, magnetic resonance imaging,
465 and a diagnostic radionuclide laboratory.
466
467 II.D.4. Other Facilities, Resources, or Support Services
468
469 II.D.4.a) There must be surgical and pathological support available for the
470 modern practice of nephrology, including an active renal
471 transplant service.
472
473 II.D.4.b) Surgery for vascular and peritoneal dialysis access must be
474 available.
475
476 II.D.4.c) The primary ~~training clinical~~ site must be approved to perform
477 renal transplantation, or must have a formal written agreement
478 with such an institution, ensuring that nephrology fellows receive
479 the requisite experience with renal transplantation.
480
481 II.D.4.d) Electron and immunofluorescence microscopy, and other special
482 studies for the preparation and evaluation of renal biopsy material
483 must be available.
484
485 II.D.4.e) The program must provide acute and chronic hemodialysis,
486 continuous renal replacement therapy, peritoneal dialysis, and
487 renal biopsy.
488
489 II.D.5. *Medical Records*
490
491 Access to an electronic health record should be provided. In the absence
492 of an existing electronic health record, institutions must demonstrate
493 institutional commitment to its development and progress toward its
494 implementation.
495
496 II.D.6. Patient Population
497
498 II.D.6.a) The patient population must have a variety of clinical problems
499 and stages of diseases.
500
501 II.D.6.a).(1) The ~~training~~ program should be of sufficient size to ensure
502 fellows' adequate exposure ~~of~~ to patients with acute kidney
503 injury, and a chronic dialysis ~~patient population both~~
504 hemodialysis and peritoneal dialysis including patients who
505 utilize home dialysis treatment modalities, in order to
506 ensure adequate ~~training~~ education and experience in

- 507 chronic dialysis.
- 508
- 509 *II.D.6.b) There must be patients of each gender ~~both sexes~~, with a broad*
- 510 *age range, including geriatric patients.*
- 511
- 512 *II.D.6.c) A sufficient number of patients must be available to enable ~~ensure~~*
- 513 *~~adequate inpatient and ambulatory experience for each fellow to~~*
- 514 *achieve the required educational outcomes.*
- 515
- 516 ~~II.D.6.c).(1) The training program must have access to at least 10 new-~~
- 517 ~~renal transplants per first-year fellow.~~
- 518
- 519 *II.D.6.c).(2) Each fellow must see at least 10 new renal transplant*
- 520 *patients during the course of their ~~his or her~~ fellowship.*
- 521
- 522 ~~II.D.6.c).(3) Each fellow must see transplant patients in follow up-~~
- 523 ~~clinics for a minimum of three months during the~~
- 524 ~~fellowship.~~
- 525
- 526 ~~II.D.6.c).(4) Each fellow must see at least 20 follow-up patients during~~
- 527 ~~their transplant clinic experience.~~
- 528
- 529 *II.D.6.d) The training program must afford fellows the opportunity to care-*
- 530 *for patients with renal disorders in the intensive care unit setting.*

532 **II.E. Medical Information Access**

533

534 **Fellows must have ready access to specialty-specific and other appropriate**

535 **reference material in print or electronic format. Electronic medical literature**

536 **databases with search capabilities should be available.**

537

538 **III. Fellow Appointments**

540 **III.A. Eligibility Criteria**

541

542 **The program director must comply with the criteria for fellow eligibility as**

543 **specified in the Institutional Requirements.**

544

545 *III.A.1. ~~Prior to appointment in the fellowship program, fellows appointed should~~*

546 *~~have completed an ACGME-accredited internal medicine education~~*

547 *~~program.~~*

548

549 *III.A.2. ~~Fellows from non-ACGME-accredited internal medicine education~~*

550 *~~programs must have at least three years of internal medicine~~*

551 *education*

552 *~~prior to starting the fellowship.~~*

553 *III.A.3. ~~The program director must inform non-ACGME trained applicants from~~*

554 *non-ACGME-accredited programs, prior to appointment, and in writing, of*

555 *the ABIM policies and procedures that may will affect the fellows their*

556 *eligibility for ABIM certification.*

557

558 III.A.4. *When averaged over any five-year period, a minimum of 75% of fellows in*
559 *each ~~subspecialty training program~~ must be graduates of an ACGME*
560 *accredited internal medicine ~~training program~~. ~~Non-ACGME internal~~*
561 *medicine trained fellows must have at least three years of internal*
562 *medicine training education prior to starting fellowship.*
563

564 **III.B. Number of Fellows**

565
566 **The program director may not appoint more fellows than approved by the**
567 **Review Committee, unless otherwise stated in the specialty-specific**
568 **requirements. The program's educational resources must be adequate to**
569 **support the number of fellows appointed to the program.**
570

571 III.B.1. *The ~~minimum~~ number of available fellow positions in the training program*
572 *must be at least one per year ~~not be less than the number of accredited~~*
573 *training years in the program.*
574

575 **III.C. Fellow Transfers**

576
577 **III.C.1. Before accepting a fellow who is transferring from another program,**
578 **the program director must obtain written or electronic verification of**
579 **previous educational experiences and a summative competency-**
580 **based performance evaluation of the transferring fellow.**
581

582 **III.C.2. A program director must provide timely verification of fellowship**
583 **education and summative performance evaluations for fellows who**
584 **leave the program prior to completion.**
585

586 **III.D. Appointment of Fellows and Other Learners**

587
588 **The presence of other learners (including, but not limited to, residents from**
589 **other specialties, subspecialty fellows, PhD students, and nurse**
590 **practitioners) in the program must not interfere with the appointed fellows'**
591 **education. The program director must report the presence of other learners**
592 **to the DIO and GMEC in accordance with sponsoring institution guidelines.**
593

594 **IV. Educational Program**

595
596 **IV.A. The curriculum must contain the following educational components:**

597
598 **IV.A.1. Overall educational goals for the program, which the program must**
599 **distribute to fellows and faculty annually;**
600

601 **IV.A.2. Competency-based goals and objectives for each assignment at**
602 **each educational level, which the program must distribute to fellows**
603 **and faculty annually, in either written or electronic form. These**
604 **should be reviewed by the fellow at the start of each rotation;**
605

606 **IV.A.3. Regularly scheduled didactic sessions; and,**
607

- 608 IV.A.3.a) The core curriculum must include a didactic program based upon
609 the core knowledge content in the subspecialty area.
610
- 611 IV.A.3.a).(1) The program must afford each fellow an opportunity to
612 review topics covered in conferences that he or she was
613 unable to attend.
614
- 615 IV.A.3.a).(2) Fellows must participate in clinical case conferences,
616 journal clubs, research conference, and morbidity and
617 mortality or quality improvement conferences.
618
- 619 IV.A.3.a).(3) All core conferences must have at least one faculty
620 member present, and must be scheduled as to ensure
621 peer-peer and peer-faculty interaction.
622
- 623 IV.A.3.b) Patient-based teaching must include direct interaction between
624 fellows and ~~attendings~~ faculty members, bedside teaching,
625 discussion of pathophysiology, and the use of current evidence in
626 diagnostic and therapeutic decisions. The teaching must be:
627
- 628 IV.A.3.b).(1) formally conducted on all inpatient, outpatient, and
629 consultative services; and,
630
- 631 IV.A.3.b).(2) conducted with a frequency and duration ~~sufficient to that~~
632 ensures a meaningful and continuous teaching relationship
633 between the assigned supervising faculty member(s)
634 ~~teaching attending and fellows~~.
635
- 636 IV.A.3.c) Fellows must receive instruction in practice management relevant
637 to nephrology.
638
- 639 **IV.A.4. Delineation of fellow responsibilities for patient care, progressive**
640 **responsibility for patient management, and supervision of fellows**
641 **over the continuum of the program.**
642
- 643 **IV.A.5. ACGME Competencies**
644
- 645 **The program must integrate the following ACGME competencies**
646 **into the curriculum:**
647
- 648 **IV.A.5.a) Patient Care**
649
- 650 **Fellows must be able to provide patient care that is**
651 **compassionate, appropriate, and effective for the treatment of**
652 **health problems and the promotion of health. Fellows:**
653
- 654 ~~are expected to learn~~ must demonstrate competence in the
655 practice of health promotion, disease prevention,
656 diagnosis, care, and treatment of men and women from
657 adolescence to old age, during health and all stages of
658 illness;

659
660 IV.A.5.a).(2) must ~~have formal instruction, clinical experience, and~~
661 demonstrate competence in the ~~prevention, evaluation,~~
662 and management of ~~both inpatients and outpatients with~~
663 ~~the following:~~
664
665 IV.A.5.a).(2).(a) acute kidney injury;
666
667 IV.A.5.a).(2).(b) chronic kidney disease ~~and its management;~~
668
669 IV.A.5.a).(2).(c) disorders of fluid, electrolyte, and acid-base
670 regulation;
671
672 IV.A.5.a).(2).(d) disorders of mineral metabolism, including
673 nephrolithiasis and renal osteodystrophy;
674
675 IV.A.5.a).(2).(e) drug dosing adjustments and nephrotoxicity
676 associated with alterations in drug metabolism and
677 pharmacokinetics in renal disease;
678
679 IV.A.5.a).(2).(f) end-stage renal disease;
680
681 IV.A.5.a).(2).(g) genetic and inherited renal disorders, including
682 inherited diseases of transport, cystic diseases,
683 and other congenital disorders;
684
685 IV.A.5.a).(2).(h) geriatric aspects of nephrology;
686
687 IV.A.5.a).(2).(i) glomerular and vascular diseases, including the
688 glomerulonephritides, diabetic nephropathy, and
689 atheroembolic renal disease;
690
691 IV.A.5.a).(2).(j) hypertensive disorders;
692
693 IV.A.5.a).(2).(k) renal disorders of pregnancy;
694
695 IV.A.5.a).(2).(l) tubulointerstitial renal diseases; and,
696
697 IV.A.5.a).(2).(m) urinary tract infections.
698
699 IV.A.5.a).(3) must ~~have formal instruction, clinical experience and~~
700 demonstrate competence in dialysis therapy;
701
702 IV.A.5.a).(4) must ~~have formal instruction, clinical experience and~~
703 demonstrate competence in the evaluation and
704 management of in-renal transplantation patients;
705
706 IV.A.5.a).(5) ~~Fellows must have formal instruction, clinical experience,~~
707 ~~and must demonstrate competence in the performance of~~
708 ~~the following:~~
709

- 710 IV.A.5.a).(5).(a) acute and chronic hemodialysis;
 711
 712 IV.A.5.a).(5).(b) continuous renal replacement therapy;
 713
 714 IV.A.5.a).(5).(c) percutaneous biopsy of both autologous and
 715 transplanted kidneys;
 716
 717 IV.A.5.a).(5).(d) peritoneal dialysis;
 718
 719 IV.A.5.a).(5).(e) placement of temporary vascular access for
 720 hemodialysis and related procedures; and,
 721
 722 IV.A.5.a).(5).(f) urinalysis-
 723

724 **IV.A.5.b)**

Medical Knowledge

725
 726 **Fellows must demonstrate knowledge of established and**
 727 **evolving biomedical, clinical, epidemiological and social-**
 728 **behavioral sciences, as well as the application of this**
 729 **knowledge to patient care. Fellows:**
 730

731 *IV.A.5.b).(1) ~~are expected to learn~~ must demonstrate knowledge of the*
 732 *scientific method of problem solving and evidence-based*
 733 *decision making; ~~to demonstrate a commitment to lifelong~~*
 734 *learning, and an attitude of caring that is derived from*
 735 *humanistic and professional values.*
 736

737 *IV.A.5.b).(2) ~~must develop~~ demonstrate knowledge understanding of*
 738 *indications, contraindications, limitations, complications,*
 739 *techniques, and interpretation of results of those diagnostic*
 740 *and therapeutic procedures integral to the discipline,*
 741 *including the appropriate indications for and use of*
 742 *screening tests/procedures;*
 743

744 *IV.A.5.b).(3) must demonstrate knowledge of:*
 745

746 *IV.A.5.b).(3).(a) ~~are expected to learn~~ clinical pharmacology,*
 747 *including drug metabolism, ~~and~~ pharmacokinetics,*
 748 *and the effects of drugs on renal structure and*
 749 *function;*
 750

751 *IV.A.5.b).(3).(b) ~~are expected to learn~~ dialysis and extracorporeal*
 752 *therapy, including:*
 753

754 *IV.A.5.b).(3).(b).(i) the indication for each mode of dialysis;*
 755

756 *IV.A.5.b).(3).(b).(ii) dialysis modes and their relation to*
 757 *metabolism;*
 758

759 *IV.A.5.b).(3).(b).(iii) dialysis water treatment, delivery systems,*
 760 *and reuse of artificial kidneys;*

761		
762	IV.A.5.b).(3).(b).(iv)	the kinetic principles of hemodialysis and peritoneal dialysis;
763		
764		
765	IV.A.5.b).(3).(b).(v)	the principles of dialysis access (acute and chronic vascular and peritoneal), including indications, techniques, and complications;
766		
767		
768		
769	IV.A.5.b).(3).(b).(vi)	the short- term and long-term complications of each mode of dialysis and their <u>its</u> management;
770		
771		
772		
773	IV.A.5.b).(3).(b).(vii)	the artificial membranes used in hemodialysis and biocompatibility; and,
774		
775		
776	IV.A.5.b).(3).(b).(viii)	urea kinetics and protein catabolic rate-
777		
778	IV.A.5.b).(3).(c)	are expected to learn normal and abnormal blood pressure regulation;
779		
780		
781	IV.A.5.b).(3).(d)	are expected to learn normal and disordered fluid, electrolyte and acid-base metabolism;
782		
783		
784	IV.A.5.b).(3).(e)	are expected to learn normal mineral metabolism and its alteration in renal diseases, metabolic bone disease, and nephrolithiasis;
785		
786		
787		
788	IV.A.5.b).(3).(f)	are expected to learn nutritional aspects of renal disorders;
789		
790		
791	IV.A.5.b).(3).(g)	are expected to learn immunologic aspects of renal disease;
792		
793		
794	IV.A.5.b).(3).(h)	are expected to learn indications for and interpretations of radiologic tests of the kidney and urinary tract;
795		
796		
797		
798	IV.A.5.b).(3).(i)	are expected to learn pathogenesis, natural history, and management of congenital and acquired diseases of the kidney and urinary tract, and renal diseases associated with systemic disorders;
799		
800		
801		
802		
803	IV.A.5.b).(3).(j)	are expected to learn renal anatomy, physiology, and pathology;
804		
805		
806	IV.A.5.b).(3).(k)	are expected to learn renal transplantation, including:
807		
808		
809	IV.A.5.b).(3).(k).(i)	biology of transplantation rejection;
810		
811	IV.A.5.b).(3).(k).(ii)	indications for and contraindications to <u>for</u>

812		renal transplantation;
813		
814	IV.A.5.b).(3).(k).(iii)	principles of transplant recipient evaluation and selection;
815		
816		
817	IV.A.5.b).(3).(k).(iv)	principles of evaluation of transplant donors, both living and cadaveric, including histocompatibility testing;
818		
819		
820		
821	IV.A.5.b).(3).(k).(v)	principles of organ harvesting, preservation, and sharing;
822		
823		
824	IV.A.5.b).(3).(k).(vi)	psychosocial aspects of organ donation and transplantation; and,
825		
826		
827	IV.A.5.b).(3).(k).(vii)	the pathogenesis and management of acute renal allograft dysfunction.
828		
829		
830	IV.A.5.b).(3).(l)	are expected to learn management of renal disorders in non-renal organ transplantation;
831		
832		
833	IV.A.5.b).(3).(m)	are expected to learn geriatric medicine, including:
834		
835	IV.A.5.b).(3).(m).(i)	physiology and pathology of the aging kidney; and,
836		
837		
838	IV.A.5.b).(3).(m).(ii)	drug dosing and renal toxicity in elderly patients.
839		
840		
841	IV.A.5.b).(3).(n)	the principles and practice of hemodialysis and peritoneal dialysis;
842		
843		
844	IV.A.5.b).(3).(o)	the technology of hemodialysis and peritoneal dialysis;
845		
846		
847	IV.A.5.b).(3).(p)	the pharmacology of commonly used medications and their kinetic and dosage alteration with hemodialysis and peritoneal dialysis; and,
848		
849		
850		
851	IV.A.5.b).(3).(q)	the psychosocial and ethical issues of dialysis.
852		

853 **IV.A.5.c)**

Practice-based Learning and Improvement

854
855 **Fellows must demonstrate the ability to investigate and**
856 **evaluate their care of patients, to appraise and assimilate**
857 **scientific evidence, and to continuously improve patient care**
858 **based on constant self-evaluation and life-long learning.**
859 **Fellows are expected to develop skills and habits to be able**
860 **to meet the following goals:**

- 861
862 **IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's**

- 863 knowledge and expertise;
- 864
- 865 **IV.A.5.c).(2)** set learning and improvement goals;
- 866
- 867 **IV.A.5.c).(3)** identify and perform appropriate learning activities;
- 868
- 869 **IV.A.5.c).(4)** systematically analyze practice, using quality
- 870 improvement methods, and implement changes with
- 871 the goal of practice improvement;
- 872
- 873 **IV.A.5.c).(5)** incorporate formative evaluation feedback into daily
- 874 practice;
- 875
- 876 **IV.A.5.c).(6)** locate, appraise, and assimilate evidence from
- 877 scientific studies related to their patients' health
- 878 problems;
- 879
- 880 **IV.A.5.c).(7)** use information technology to optimize learning; and,
- 881
- 882 **IV.A.5.c).(8)** participate in the education of patients, families,
- 883 students, fellows and other health professionals.

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

886

887 **Fellows must demonstrate interpersonal and communication**

888 **skills that result in the effective exchange of information and**

889 **collaboration with patients, their families, and health**

890 **professionals. Fellows are expected to:**

- 891
- 892 **IV.A.5.d).(1)** communicate effectively with patients, families, and
- 893 the public, as appropriate, across a broad range of
- 894 socioeconomic and cultural backgrounds;
- 895
- 896 **IV.A.5.d).(2)** communicate effectively with physicians, other health
- 897 professionals, and health related agencies;
- 898
- 899 **IV.A.5.d).(3)** work effectively as a member or leader of a health care
- 900 team or other professional group;
- 901
- 902 **IV.A.5.d).(4)** act in a consultative role to other physicians and
- 903 health professionals; and,
- 904
- 905 **IV.A.5.d).(5)** maintain comprehensive, timely, and legible medical
- 906 records, if applicable.

907

908 **IV.A.5.e)** **Professionalism**

909

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

911 **professional responsibilities and an adherence to ethical**

912 **principles. Fellows are expected to demonstrate:**

913		
914	IV.A.5.e).(1)	compassion, integrity, and respect for others;
915		
916	IV.A.5.e).(2)	responsiveness to patient needs that supersedes self-interest;
917		
918		
919	IV.A.5.e).(3)	respect for patient privacy and autonomy;
920		
921	IV.A.5.e).(4)	accountability to patients, society and the profession;
922		
923	IV.A.5.e).(5)	sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation;
924		
925		
926		
927		
928	IV.A.5.e).(6)	<u>high standards of ethical behavior, including maintaining appropriate professional boundaries, relationships with other physicians and other health care team members and conflicts of interest; and,</u>
929		
930		
931		
932		
933	IV.A.5.e).(7)	<i>a commitment to lifelong learning, and an attitude of caring derived from humanistic and professional values.</i>
934		
935		
936	IV.A.5.f)	Systems-based Practice
937		
938		Fellows must demonstrate an awareness of and
939		responsiveness to the larger context and system of health
940		care, as well as the ability to call effectively on other
941		resources in the system to provide optimal health care.
942		Fellows are expected to:
943		
944	IV.A.5.f).(1)	work effectively in various health care delivery settings and systems relevant to their clinical specialty;
945		
946		
947		
948	IV.A.5.f).(2)	coordinate patient care within the health care system relevant to their clinical specialty;
949		
950		
951	IV.A.5.f).(3)	incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
952		
953		
954		
955	IV.A.5.f).(4)	advocate for quality patient care and optimal patient care systems;
956		
957		
958	IV.A.5.f).(5)	work in interprofessional teams to enhance patient safety and improve patient care quality; and,
959		
960		
961	IV.A.5.f).(6)	participate in identifying system errors and implementing potential systems solutions.
962		

963		
964	IV.A.6.	<u>Curriculum Organization and Fellow Experiences</u>
965		
966	IV.A.6.a)	A minimum of 12 months must be devoted to clinical experience.
967		
968	IV.A.6.a).(1)	During the equivalent of Fellows should have at least four months of the training program, the fellow should have exposure <u>experience with</u> dialysis therapies, both hemodialysis and peritoneal dialysis.
969		
970		
971		
972		
973	IV.A.6.a).(2)	Must have instruction in, and Fellows must have at least minimum of two months of clinical experience on an active renal transplant service.
974		
975		
976		
977	IV.A.6.b)	<u>Fellows must participate in training using simulation.</u>
978		
979	IV.A.6.c)	Experience with Continuity Ambulatory Patients
980		
981		Fellows must have continuity ambulatory clinic experience to
982		develop a continuous healing relationship with patients for whom
983		they provide subspecialty care. This continuity experience should
984		<u>that exposes fellows them</u> to the breadth and depth of nephrology.
985		
986	IV.A.6.c).(1)	Overall The experience should average one half-day each week.
987		
988		
989	IV.A.6.c).(2)	Overall The experience must include an appropriate distribution of patients of each gender and a diversity of ages, <u>which</u> . This should be accomplished by <u>through</u> either:
990		
991		
992		
993		
994	IV.A.6.c).(2).(a)	a continuity clinic which provides fellows the opportunity to learn the course of disease; or,
995		
996		
997	IV.A.6.c).(2).(b)	selected blocks of at least six months which address specific areas of nephrology.
998		
999		
1000	IV.A.6.c).(3)	Each fellow should, on average, be responsible for four to eight patients during each half-day session.
1001		
1002		
1003	IV.A.6.c).(4)	The continuing <u>ambulatory</u> patient care experience should not be interrupted by more than one month, excluding a fellow's vacation.
1004		
1005		
1006		
1007	IV.A.6.c).(5)	It is suggested that Fellows should be informed of the status of their continuity patients when <u>they such patients</u> are hospitalized, <u>as clinically appropriate</u> . so the fellows can make appropriate arrangements to maintain continuity of care.
1008		
1009		
1010		
1011		
1012		
1013	IV.A.6.d)	Clinical experience must entail <u>include</u> supervised involvement in

- 1014 ~~decision making for patients undergoing dialysis therapies. This~~
 1015 ~~experience must include~~, including:
 1016
- 1017 IV.A.6.d).(1) assessment of hemodialysis and peritoneal dialysis
 1018 efficiency;
 - 1019
 - 1020 IV.A.6.d).(2) the complications of hemodialysis and peritoneal dialysis;
 - 1021
 - 1022 IV.A.6.d).(3) ~~the determining~~ special nutritional requirements of patients
 1023 undergoing hemodialysis and peritoneal dialysis;
 - 1024
 - 1025 IV.A.6.d).(4) end-of-life care and pain management ~~in the care of for~~
 1026 patients undergoing chronic hemodialysis and peritoneal
 1027 dialysis;
 - 1028
 - 1029 IV.A.6.d).(5) evaluation of end-stage renal disease patients for
 1030 peritoneal dialysis and hemodialysis, and their instruction
 1031 regarding these treatment options;
 - 1032
 - 1033 IV.A.6.d).(6) evaluation and management of medical complications in
 1034 patients during and between hemodialysis and peritoneal
 1035 dialyses;
 - 1036
 - 1037 IV.A.6.d).(7) evaluation and selection of patients for acute hemodialysis
 1038 or continuous renal replacement therapies;
 - 1039
 - 1040 IV.A.6.d).(8) long-term follow-up of patients undergoing chronic
 1041 hemodialysis and peritoneal dialysis;
 - 1042
 - 1043 IV.A.6.d).(9) modification of drug dosage during hemodialysis and
 1044 peritoneal dialysis; and,
 - 1045
 - 1046 IV.A.6.d).(10) writing a hemodialysis and peritoneal dialysis prescription
 1047 and how to assess dialysis adequacy.
 - 1048
 - 1049 IV.A.6.e) Clinical experience must ~~entail~~ include supervised involvement in
 1050 ~~the decision-making for patients during the pre- and post-~~
 1051 ~~transplant care, including. This experience must include:~~
 - 1052
 - 1053 IV.A.6.e).(1) clinical and laboratory diagnosis of all forms of rejection;
 - 1054
 - 1055 IV.A.6.e).(2) evaluation and selection of transplant candidates;
 - 1056
 - 1057 IV.A.6.e).(3) immediate postoperative management of transplant
 1058 recipients, including administration of
 1059 immunosuppressants to a minimum of 10 new renal
 1060 transplant recipients;
 - 1061
 - 1062 IV.A.6.e).(4) management in the ambulatory setting for at least three
 1063 months of at least 20 patients per fellow;
 - 1064

- 1065 IV.A.6.e).(5) ~~The training program must afford fellows the opportunity to~~
1066 ~~care for management in the intensive care unit setting for~~
1067 ~~patients with renal disorders in the intensive care unit~~
1068 ~~setting;~~
- 1069
- 1070 IV.A.6.e).(6) medical management of rejection, including use of
1071 immunosuppressive drugs and other agents;
- 1072
- 1073 IV.A.6.e).(7) preoperative evaluation and preparation of transplant
1074 recipients and donors;
- 1075
- 1076 IV.A.6.e).(8) ~~the~~ psychosocial and ethical issues of renal
1077 transplantation; and,
- 1078
- 1079 IV.A.6.e).(9) recognition and medical management of the surgical and
1080 nonsurgical complications of transplantations.
- 1081
- 1082 IV.A.6.f) Procedures and Technical Skills
- 1083
- 1084 IV.A.6.f).(1) *Direct faculty supervision of procedures performed by each*
1085 *fellow must occur until proficiency has been acquired and*
1086 *documented by the program director.*
- 1087
- 1088 IV.A.6.f).(2) ~~A skilled preceptor~~ Faculty ~~must be available to teach and~~
1089 ~~supervise the fellows in the performance and interpretation~~
1090 ~~of these procedures.~~ Procedures which must be
1091 documented in each fellow's record, including indications,
1092 outcomes, diagnoses, and supervisor(s).
- 1093
- 1094 IV.A.6.f).(3) Fellows must have formal instruction regarding indications
1095 for and in interpretation of the results of ~~the following~~:
- 1096
- 1097 IV.A.6.f).(3).(a) balloon angioplasty of vascular access and other
1098 procedures utilized in the maintenance of chronic
1099 vascular access patency;
- 1100
- 1101 IV.A.6.f).(3).(b) management of peritoneal catheters;
- 1102
- 1103 IV.A.6.f).(3).(c) radiology of vascular access;
- 1104
- 1105 IV.A.6.f).(3).(d) renal imaging; and,
- 1106
- 1107 IV.A.6.f).(3).(e) therapeutic plasmapheresis.
- 1108
- 1109 IV.A.6.f).(4) ~~The Fellows must~~ have experience ~~be given opportunities~~
1110 ~~to function~~ in the role of a nephrology consultant in both
1111 the inpatient and outpatient settings.
- 1112
- 1113 **IV.B. Fellows' Scholarly Activities**
- 1114
- 1115 **IV.B.1. The curriculum must advance fellows' knowledge of the basic**

- 1116 principles of research, including how research is conducted,
 1117 evaluated, explained to patients, and applied to patient care.
 1118
 1119 **IV.B.2. Fellows should participate in scholarly activity.**
 1120
 1121 *IV.B.2.a) The majority of fellows must demonstrate evidence of ~~recent~~*
 1122 *~~research productivity~~ scholarship conducted during the fellowship*
 1123 *through one or more of the following:*
 1124
 1125 *IV.B.2.a).(1) publication of articles, book chapters, abstracts, or case*
 1126 *reports in peer-reviewed journals;*
 1127
 1128 *IV.B.2.a).(2) publication of peer-reviewed performance improvement or*
 1129 *education research;*
 1130
 1131 *IV.B.2.a).(3) peer-reviewed funding; or,*
 1132
 1133 *IV.B.2.a).(4) peer-reviewed abstracts presented at regional, state, or*
 1134 *national specialty meetings.*
 1135
 1136 **IV.B.3. The sponsoring institution and program should allocate adequate**
 1137 **educational resources to facilitate fellow involvement in scholarly**
 1138 **activities.**
 1139
 1140 **V. Evaluation**
 1141
 1142 **V.A. Fellow**
 1143
 1144 **V.A.1. Formative Evaluation**
 1145
 1146 **V.A.1.a) The faculty must evaluate fellow performance in a timely**
 1147 **manner during each rotation or similar educational**
 1148 **assignment, and document this evaluation at completion of**
 1149 **the assignment.**
 1150
 1151 *V.A.1.a).(1) The faculty must discuss this evaluation with ~~the~~ each*
 1152 *fellow at the completion of ~~the~~ each assignment.*
 1153
 1154 *V.A.1.a).(2) Assessment of procedural competence should include a*
 1155 *formal evaluation process and not be based solely on a*
 1156 *minimum number of procedures performed.*
 1157
 1158 **V.A.1.b) The program must:**
 1159
 1160 **V.A.1.b).(1) provide objective assessments of competence in**
 1161 **patient care, medical knowledge, practice-based**
 1162 **learning and improvement, interpersonal and**
 1163 **communication skills, professionalism, and systems-**
 1164 **based practice;**
 1165

1166	V.A. 1.b).(1).(a)	<u>Patient Care</u>
1167		
1168		<u>The program must assess the fellow in data</u>
1169		<u>gathering, clinical reasoning, patient management</u>
1170		<u>and procedures in both the inpatient and outpatient</u>
1171		<u>setting. This assessment must involve direct</u>
1172		<u>observation of fellow-patient encounters.</u>
1173		
1174	V.A. 1.b).(1).(a).(i)	<u>Each program must define a standard</u>
1175		<u>criteria for proficiency competence for all</u>
1176		<u>required and elective procedures.</u>
1177		
1178	V.A. 1.b).(1).(a).(ii)	<u>The record of evaluation must include the</u>
1179		<u>fellow's logbook or an equivalent method to</u>
1180		<u>demonstrate that each fellow has achieved</u>
1181		<u>competence in the performance of required</u>
1182		<u>procedures.</u>
1183		
1184	V.A. 1.b).(1).(b)	<u>Medical Knowledge</u>
1185		
1186		<u>The program must use an objective formative</u>
1187		<u>assessment method. The same formative</u>
1188		<u>assessment method must be administered at least</u>
1189		<u>twice during the program.</u>
1190		
1191	V.A. 1.b).(1).(c)	<u>Practice-based Learning and Improvement</u>
1192		
1193		<u>The program must use performance data to assess</u>
1194		<u>fellow in:</u>
1195		
1196	V.A. 1.b).(1).(c).(i)	<u>application of evidence to patient care;</u>
1197		
1198	V.A. 1.b).(1).(c).(ii)	<u>practice improvement;</u>
1199		
1200	V.A. 1.b).(1).(c).(iii)	<u>teaching skills involving peers and patients;</u>
1201		<u>and,</u>
1202		
1203	V.A. 1.b).(1).(c).(iv)	<u>scholarship.</u>
1204		
1205	V.A. 1.b).(1).(d)	<u>Interpersonal and Communication Skills</u>
1206		
1207		<u>The program must use both direct observation and</u>
1208		<u>multi-source evaluation, including patients, peers</u>
1209		<u>and non-physician team members, to assess fellow</u>
1210		<u>performance in:</u>
1211		
1212	V.A. 1.b).(1).(d).(i)	<u>communication with patient and family;</u>
1213		
1214	V.A. 1.b).(1).(d).(ii)	<u>teamwork;</u>
1215		
1216	V.A. 1.b).(1).(d).(iii)	<u>communication with peers, including</u>

1217		<u>transitions in care; and,</u>
1218		
1219	V.A. 1.b).(1).(d).(iv)	<u>record keeping.</u>
1220		
1221	V.A. 1.b).(1).(e)	<u>Professionalism</u>
1222		
1223		<u>The program must use multi-source evaluation,</u>
1224		<u>including patients, peers, and non-physician team</u>
1225		<u>members, to assess each fellow's:</u>
1226		
1227	V.A. 1.b).(1).(e).(i)	<u>honesty and integrity;</u>
1228		
1229	V.A. 1.b).(1).(e).(ii)	<u>ability to meet professional responsibilities;</u>
1230		
1231	V.A. 1.b).(1).(e).(iii)	<u>ability to maintain appropriate professional</u>
1232		<u>relationships with patients and colleagues;</u>
1233		<u>and,</u>
1234		
1235	V.A. 1.b).(1).(e).(iv)	<u>commitment to self-improvement.</u>
1236		
1237	V.A. 1.b).(1).(f)	<u>Systems-based Practice</u>
1238		
1239		<u>The program must use multi-source evaluation,</u>
1240		<u>including peers and non-physician team members,</u>
1241		<u>to assess each fellow's:</u>
1242		
1243	V.A. 1.b).(1).(f).(i)	<u>ability to provide care coordination,</u>
1244		<u>including transition of care;</u>
1245		
1246	V.A. 1.b).(1).(f).(ii)	<u>ability to work in interdisciplinary teams;</u>
1247		
1248	V.A. 1.b).(1).(f).(iii)	<u>advocacy for quality of care; and,</u>
1249		
1250	V.A. 1.b).(1).(f).(iv)	<u>ability to identify system problems and</u>
1251		<u>participate in improvement activities.</u>
1252		
1253	V.A.1.b).(2)	use multiple evaluators (e.g., faculty, peers, patients,
1254		self, and other professional staff);
1255		
1256	V.A.1.b).(3)	document progressive fellow performance
1257		improvement appropriate to educational level; and,
1258		
1259	V.A.1.b).(4)	provide each fellow with documented semiannual
1260		evaluation of performance with feedback.
1261		
1262	V.A.1.b).(4).(a)	<i>Fellows' performance in continuity clinic must be</i>
1263		<i>reviewed with them verbally and in writing at least</i>
1264		<i>semiannually.</i>
1265		
1266	V.A.1.c)	The evaluations of fellow performance must be accessible for
1267		review by the fellow, in accordance with institutional policy.

- 1268
1269 **V.A.2. Summative Evaluation**
1270
1271 The program director must provide a summative evaluation for each
1272 fellow upon completion of the program. This evaluation must
1273 become part of the fellow's permanent record maintained by the
1274 institution, and must be accessible for review by the fellow in
1275 accordance with institutional policy. This evaluation must:
1276
- 1277 **V.A.2.a)** document the fellow's performance during the final period of
1278 education; and,
1279
- 1280 **V.A.2.b)** verify that the fellow has demonstrated sufficient competence
1281 to enter practice without direct supervision.
1282
- 1283 **V.B. Faculty Evaluation**
1284
- 1285 **V.B.1.** At least annually, the program must evaluate faculty performance as
1286 it relates to the educational program.
1287
- 1288 **V.B.2.** These evaluations should include a review of faculty's clinical
1289 teaching abilities, commitment to the educational program, clinical
1290 knowledge, professionalism, and scholarly activities.
1291
- 1292 **V.B.3.** This evaluation must include at least annual written confidential
1293 evaluations by fellows.
1294
- 1295 **V.B.3.a)** ~~In addition, Fellows must have the opportunity to provide~~
1296 ~~confidential written evaluations of each supervising faculty~~
1297 ~~member at the end of a each rotation.~~
1298
- 1299 **V.B.3.b)** ~~The program director must be reviewed~~ These evaluations must
1300 be reviewed with each attending faculty member annually.
1301
- 1302 **V.C. Program Evaluation and Improvement**
1303
- 1304 **V.C.1.** The program must document formal, systematic evaluation of the
1305 curriculum at least annually. The program must monitor and track
1306 each of the following areas:
1307
- 1308 **V.C.1.a)** fellow performance;
1309
- 1310 **V.C.1.b)** faculty development;
1311
- 1312 **V.C.1.c)** graduate performance, including performance of program
1313 graduates on the certification examination; and,
1314
- 1315 **V.C.1.c).(1)** ~~At least 80% of program's graduating fellows from those~~
1316 ~~eligible to take an ABIM subspecialty certifying~~
1317 ~~examination upon completion of their training for the most~~

- 1318 *recently defined five year period who are eligible should*
 1319 *must have taken an the ABIM subspecialty certifying*
 1320 *examination. (Note: Five-year rolling pass rate for first time*
 1321 *takers of the ABIM certifying examination will be examined*
 1322 *at each program review).*
- 1323
- 1324 V.C.1.c).(2) *At least 80% of a program's graduates taking the ABIM*
 1325 *certifying examination for the first time during the most*
 1326 *recently defined five year period should pass.*
- 1327
- 1328 V.C.1.d) **program quality. Specifically:**
- 1329
- 1330 V.C.1.d).(1) **Fellows and faculty must have the opportunity to**
 1331 **evaluate the program confidentially and in writing at**
 1332 **least annually.**
- 1333
- 1334 V.C.1.d).(2) **The program must use the results of fellows'**
 1335 **assessments of the program together with other**
 1336 **program evaluation results to improve the program.**
- 1337
- 1338 V.C.1.d).(3) *At least 80% of the entering fellows should have*
 1339 *completed the program when averaged over a five-year*
 1340 *period.*
- 1341
- 1342 V.C.2. **If deficiencies are found, the program should prepare a written plan**
 1343 **of action to document initiatives to improve performance in the**
 1344 **areas listed in section V.C.1. The action plan should be reviewed**
 1345 **and approved by the teaching faculty and documented in meeting**
 1346 **minutes.**
- 1347
- 1348 V.C.3. *Representative program personnel, at a minimum to include the program*
 1349 *director, representative faculty, and one fellow, must review program*
 1350 *goals and objectives, and the effectiveness with which they are achieved.*
- 1351
- 1352 VI. **Fellow Duty Hours in the Learning and Working Environment**
- 1353
- 1354 VI.A. **Professionalism, Personal Responsibility, and Patient Safety**
- 1355
- 1356 VI.A.1. **Programs and sponsoring institutions must educate fellows and**
 1357 **faculty members concerning the professional responsibilities of**
 1358 **physicians to appear for duty appropriately rested and fit to provide**
 1359 **the services required by their patients.**
- 1360
- 1361 VI.A.2. **The program must be committed to and responsible for promoting**
 1362 **patient safety and fellow well-being in a supportive educational**
 1363 **environment.**
- 1364
- 1365 VI.A.3. **The program director must ensure that fellows are integrated and**
 1366 **actively participate in interdisciplinary clinical quality improvement**
 1367 **and patient safety programs.**

- 1368
- 1369 **VI.A.4. The learning objectives of the program must:**
- 1370
- 1371 **VI.A.4.a) be accomplished through an appropriate blend of supervised**
- 1372 **patient care responsibilities, clinical teaching, and didactic**
- 1373 **educational events; and,**
- 1374
- 1375 **VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill**
- 1376 **non-physician service obligations.**
- 1377
- 1378 ~~VI.A.4.b).(1) ————— *Fellows' service responsibilities must be limited to patients*~~
- 1379 ~~*for whom the teaching service has diagnostic and*~~
- 1380 ~~*therapeutic responsibility.*~~
- 1381
- 1382 **VI.A.5. The program director and institution must ensure a culture of**
- 1383 **professionalism that supports patient safety and personal**
- 1384 **responsibility. Fellows and faculty members must demonstrate an**
- 1385 **understanding and acceptance of their personal role in the**
- 1386 **following:**
- 1387
- 1388 **VI.A.5.a) assurance of the safety and welfare of patients entrusted to**
- 1389 **their care;**
- 1390
- 1391 **VI.A.5.b) provision of patient- and family-centered care;**
- 1392
- 1393 **VI.A.5.c) assurance of their fitness for duty;**
- 1394
- 1395 **VI.A.5.d) management of their time before, during, and after clinical**
- 1396 **assignments;**
- 1397
- 1398 **VI.A.5.e) recognition of impairment, including illness and fatigue, in**
- 1399 **themselves and in their peers;**
- 1400
- 1401 **VI.A.5.f) attention to lifelong learning;**
- 1402
- 1403 **VI.A.5.g) the monitoring of their patient care performance improvement**
- 1404 **indicators; and,**
- 1405
- 1406 **VI.A.5.h) honest and accurate reporting of duty hours, patient**
- 1407 **outcomes, and clinical experience data.**
- 1408
- 1409 **VI.A.6. All fellows and faculty members must demonstrate responsiveness**
- 1410 **to patient needs that supersedes self-interest. Physicians must**
- 1411 **recognize that under certain circumstances, the best interests of the**
- 1412 **patient may be served by transitioning that patient's care to another**
- 1413 **qualified and rested provider.**
- 1414
- 1415 **VI.B. Transitions of Care**
- 1416
- 1417 **VI.B.1. Programs must design clinical assignments to minimize the number**

- 1418 of transitions in patient care.
- 1419
- 1420 **VI.B.2.** Sponsoring institutions and programs must ensure and monitor
- 1421 effective, structured hand-over processes to facilitate both
- 1422 continuity of care and patient safety.
- 1423
- 1424 **VI.B.3.** Programs must ensure that fellows are competent in communicating
- 1425 with team members in the hand-over process.
- 1426
- 1427 **VI.B.4.** The sponsoring institution must ensure the availability of schedules
- 1428 that inform all members of the health care team of attending
- 1429 physicians and fellows currently responsible for each patient's care.
- 1430
- 1431 **VI.C.** Alertness Management/Fatigue Mitigation
- 1432
- 1433 **VI.C.1.** The program must:
- 1434
- 1435 **VI.C.1.a)** educate all faculty members and fellows to recognize the
- 1436 signs of fatigue and sleep deprivation;
- 1437
- 1438 **VI.C.1.b)** educate all faculty members and fellows in alertness
- 1439 management and fatigue mitigation processes; and,
- 1440
- 1441 **VI.C.1.c)** adopt fatigue mitigation processes to manage the potential
- 1442 negative effects of fatigue on patient care and learning, such
- 1443 as naps or back-up call schedules.
- 1444
- 1445 **VI.C.2.** Each program must have a process to ensure continuity of patient
- 1446 care in the event that a fellow may be unable to perform his/her
- 1447 patient care duties.
- 1448
- 1449 **VI.C.3.** The sponsoring institution must provide adequate sleep facilities
- 1450 and/or safe transportation options for fellows who may be too
- 1451 fatigued to safely return home.
- 1452
- 1453 **VI.D.** Supervision of Fellows
- 1454
- 1455 **VI.D.1.** In the clinical learning environment, each patient must have an
- 1456 identifiable, appropriately-credentialed and privileged attending
- 1457 physician (or licensed independent practitioner as approved by each
- 1458 Review Committee) who is ultimately responsible for that patient's
- 1459 care.
- 1460
- 1461 **VI.D.1.a)** This information should be available to fellows, faculty
- 1462 members, and patients.
- 1463
- 1464 **VI.D.1.b)** Fellows and faculty members should inform patients of their
- 1465 respective roles in each patient's care.
- 1466
- 1467 **VI.D.2.** The program must demonstrate that the appropriate level of

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

1480
1481 **VI.D.3. Levels of Supervision**

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

1486
1487 **VI.D.3.a) Direct Supervision – the supervising physician is physically**
1488 **present with the fellow and patient.**

1489
1490 **VI.D.3.b) Indirect Supervision:**

1491
1492 **VI.D.3.b).(1) with direct supervision immediately available – the**
1493 **supervising physician is physically within the hospital**
1494 **or other site of patient care, and is immediately**
1495 **available to provide Direct Supervision.**

1496
1497 **VI.D.3.b).(2) with direct supervision available – the supervising**
1498 **physician is not physically present within the hospital**
1499 **or other site of patient care, but is immediately**
1500 **available by means of telephonic and/or electronic**
1501 **modalities, and is available to provide Direct**
1502 **Supervision.**

1503
1504 **VI.D.3.c) Oversight – the supervising physician is available to provide**
1505 **review of procedures/encounters with feedback provided**
1506 **after care is delivered.**

1507
1508 **VI.D.4. The privilege of progressive authority and responsibility, conditional**
1509 **independence, and a supervisory role in patient care delegated to**
1510 **each fellow must be assigned by the program director and faculty**
1511 **members.**

1512
1513 **VI.D.4.a) The program director must evaluate each fellow’s abilities**
1514 **based on specific criteria. When available, evaluation should**
1515 **be guided by specific national standards-based criteria.**

1516
1517 **VI.D.4.b) Faculty members functioning as supervising physicians**

1518 should delegate portions of care to fellows, based on the
1519 needs of the patient and the skills of the fellows.
1520

1521 **VI.D.4.c)** Senior residents or fellows should serve in a supervisory role
1522 of junior residents in recognition of their progress toward
1523 independence, based on the needs of each patient and the
1524 skills of the individual resident or fellow.
1525

1526 **VI.D.5.** Programs must set guidelines for circumstances and events in
1527 which fellows must communicate with appropriate supervising
1528 faculty members, such as the transfer of a patient to an intensive
1529 care unit, or end-of-life decisions.
1530

1531 **VI.D.5.a)** Each fellow must know the limits of his/her scope of
1532 authority, and the circumstances under which he/she is
1533 permitted to act with conditional independence.
1534

1535 **VI.D.5.a).(1)** In particular, PGY-1 residents should be supervised
1536 either directly or indirectly with direct supervision
1537 immediately available.
1538

1539 **VI.D.6.** Faculty supervision assignments should be of sufficient duration to
1540 assess the knowledge and skills of each fellow and delegate to
1541 him/her the appropriate level of patient care authority and
1542 responsibility.
1543

1544 **VI.E.** **Clinical Responsibilities**

1545
1546 The clinical responsibilities for each fellow must be based on PGY-level,
1547 patient safety, fellow education, severity and complexity of patient
1548 illness/condition and available support services.
1549

1550 **VI.F.** **Teamwork**

1551
1552 Fellows must care for patients in an environment that maximizes effective
1553 communication. This must include the opportunity to work as a member of
1554 effective interprofessional teams that are appropriate to the delivery of care
1555 in the specialty.
1556

1557 **VI.G.** **Fellow Duty Hours**

1558

1559 **VI.G.1.** **Maximum Hours of Work per Week**

1560
1561 Duty hours must be limited to 80 hours per week, averaged over a
1562 four-week period, inclusive of all in-house call activities and all
1563 moonlighting.
1564

1565 **VI.G.1.a)** **Duty Hour Exceptions**

1566
1567 A Review Committee may grant exceptions for up to 10% or a

1568 maximum of 88 hours to individual programs based on a
1569 sound educational rationale.
1570
1571 *The Review Committee for Internal Medicine will not consider*
1572 *requests for exceptions to the 80-hour limit to the fellows' work*
1573 *week.*
1574
1575 **VI.G.1.a).(1)** In preparing a request for an exception the program
1576 director must follow the duty hour exception policy
1577 from the ACGME Manual on Policies and Procedures.
1578
1579 **VI.G.1.a).(2)** Prior to submitting the request to the Review
1580 Committee, the program director must obtain approval
1581 of the institution's GMEC and DIO.
1582
1583 **VI.G.2. Moonlighting**
1584
1585 **VI.G.2.a)** Moonlighting must not interfere with the ability of the fellow
1586 to achieve the goals and objectives of the educational
1587 program.
1588
1589 **VI.G.2.b)** Time spent by fellows in Internal and External Moonlighting
1590 (as defined in the ACGME Glossary of Terms) must be
1591 counted towards the 80-hour Maximum Weekly Hour Limit.
1592
1593 **VI.G.2.c)** PGY-1 residents are not permitted to moonlight.
1594
1595 **VI.G.3. Mandatory Time Free of Duty**
1596
1597 Fellows must be scheduled for a minimum of one day free of duty
1598 every week (when averaged over four weeks). At-home call cannot
1599 be assigned on these free days.
1600
1601 **VI.G.4. Maximum Duty Period Length**
1602
1603 **VI.G.4.a)** Duty periods of PGY-1 residents must not exceed 16 hours in
1604 duration.
1605
1606 **VI.G.4.b)** Duty periods of PGY-2 residents and above may be
1607 scheduled to a maximum of 24 hours of continuous duty in
1608 the hospital. Programs must encourage fellows to use
1609 alertness management strategies in the context of patient
1610 care responsibilities. Strategic napping, especially after 16
1611 hours of continuous duty and between the hours of 10:00
1612 p.m. and 8:00 a.m., is strongly suggested.
1613
1614 **VI.G.4.b).(1)** It is essential for patient safety and fellow education
1615 that effective transitions in care occur. Fellows may be
1616 allowed to remain on-site in order to accomplish these
1617 tasks; however, this period of time must be no longer

1618 than an additional four hours.

1619

1620 **VI.G.4.b).(2)** **Fellows must not be assigned additional clinical**

1621 **responsibilities after 24 hours of continuous in-house**

1622 **duty.**

1623

1624 **VI.G.4.b).(3)** **In unusual circumstances, fellows, on their own**

1625 **initiative, may remain beyond their scheduled period**

1626 **of duty to continue to provide care to a single patient.**

1627 **Justifications for such extensions of duty are limited**

1628 **to reasons of required continuity for a severely ill or**

1629 **unstable patient, academic importance of the events**

1630 **transpiring, or humanistic attention to the needs of a**

1631 **patient or family.**

1632

1633 **VI.G.4.b).(3).(a)** **Under those circumstances, the fellow must:**

1634

1635 **VI.G.4.b).(3).(a).(i)** **appropriately hand over the care of all**

1636 **other patients to the team responsible**

1637 **for their continuing care; and,**

1638

1639 **VI.G.4.b).(3).(a).(ii)** **document the reasons for remaining to**

1640 **care for the patient in question and**

1641 **submit that documentation in every**

1642 **circumstance to the program director.**

1643

1644 **VI.G.4.b).(3).(b)** **The program director must review each**

1645 **submission of additional service, and track**

1646 **both individual fellow and program-wide**

1647 **episodes of additional duty.**

1648

1649 **VI.G.5. Minimum Time Off between Scheduled Duty Periods**

1650

1651 **VI.G.5.a)** **PGY-1 residents should have 10 hours, and must have eight**

1652 **hours, free of duty between scheduled duty periods.**

1653

1654 **VI.G.5.b)** **Residents in the final years of education must be prepared to**

1655 **enter the unsupervised practice of medicine and care for**

1656 **patients over irregular or extended periods.**

1657

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

1659 *final years of education.*

1660

1661 **VI.G.5.c)** **Intermediate-level residents have 10 hours free of duty, and**

1662 **must have eight hours between scheduled duty periods. They**

1663 **must have at least 14 hours free of duty after 24 hours of in-**

1664 **house duty.**

1665

1666 *Internal medicine subspecialty fellows are considered to be in the*

1667 *final years of education.*

1668
1669 **VI.G.5.c).(1)** This preparation must occur within the context of the
1670 **80-hour, maximum duty period length, and one-day-**
1671 **off-in-seven standards. While it is desirable that**
1672 **fellows in their final years of education have eight**
1673 **hours free of duty between scheduled duty periods,**
1674 **there may be circumstances when these fellows must**
1675 **stay on duty to care for their patients or return to the**
1676 **hospital with fewer than eight hours free of duty.**
1677
1678 **VI.G.5.c).(1).(a)** **Circumstances of return-to-hospital activities**
1679 **with fewer than eight hours away from the**
1680 **hospital by fellows in their final years of**
1681 **education must be monitored by the program**
1682 **director.**
1683
1684 **VI.G.5.c).(1).(b)** *In unusual circumstances, fellows may remain*
1685 *beyond their scheduled period of duty or return*
1686 *after their scheduled period of duty to provide care*
1687 *to a single patient. Justifications for such*
1688 *extensions of duty are limited to reasons of*
1689 *required continuity of care for a severely ill or*
1690 *unstable patient, academic importance of the*
1691 *events transpiring, or humanistic attention to the*
1692 *needs of the patient or family. Such episodes*
1693 *should be rare, must be of the fellows' own*
1694 *initiative, and need not initiate a new 'off-duty*
1695 *period' nor require a change in the scheduled 'off-*
1696 *duty period.'*
1697
1698 **VI.G.5.c).(1).(c)** *Under such circumstances, the fellow must*
1699 *appropriately hand over care of all other patients to*
1700 *the team responsible for their continuing care, and*
1701 *document the reasons for remaining or returning to*
1702 *care for the patient in question and submit that*
1703 *documentation to the program director.*
1704
1705 **VI.G.5.c).(1).(d)** *The program director must review each submission*
1706 *of additional service and track both individual*
1707 *fellows' and program-wide episodes of additional*
1708 *duty.*
1709
1710 **VI.G.6. Maximum Frequency of In-House Night Float**
1711
1712 **Fellows must not be scheduled for more than six consecutive nights**
1713 **of night float.**
1714
1715 **VI.G.7. Maximum In-House On-Call Frequency**
1716
1717 **PGY-2 residents and above must be scheduled for in-house call no**

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

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

1751
1752 ***

1753
1754 ACGME Approved: February 5, 2011 Effective: July 1, 2012