

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Pulmonary Disease (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. Pulmonary disease medicine focuses on the etiology, diagnosis, prevention, and**
35 **treatment of diseases affecting the lungs and related organs. Subspecialty-**
36 **programs must Pulmonary disease fellowships provide advanced training-**
37 **education to allow the a fellow to acquire competency in the subspecialty with**
38 **sufficient expertise to act as an independent consultant.**

39
40 **Int.C. ~~An accredited fellowship-~~The educational program in pulmonary disease must**
41 **provide be 24 months of supervised graduate medical education in length.**

42
43 **I. Institutions**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

98
99 I.A.3.f) ~~provide fellowship positions per year; and in each training program~~
100 ~~that do not number than the number of accredited training at least~~
101 ~~one fellow per year; and~~

102

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

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

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

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

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

354 II.B.6. The physician faculty must meet professional standards of ethical
355 behavior.
356

357 II.B.7. Key Clinical Faculty
358
359 In addition to the program director, each program must have at least two
360 Key Clinical Faculty (KCF). KCF are attending physicians who dedicate,
361 on average, 10 hours per week throughout the year to the training-
362 program. For programs with more than four fellows, in the accredited-
363 portion of the training program, a ratio of key clinical faculty to fellows of
364 at least 1: there must be at least one KCF for every 1.5 fellows must be
365 maintained.
366

367 II.B.7.a) Key Clinical Faculty Qualifications
368

369 II.B.7.a).(1) KCF must be active clinicians with ~~bread~~ knowledge of,
370 experience with, and commitment to pulmonary disease as
371 a discipline.
372

373 II.B.7.a).(2) KCF must have current ABIM certification in pulmonary
374 disease.
375

376 II.B.7.b) Key Clinical Faculty Responsibilities
377

378 II.B.7.b).(1) In addition to the responsibilities of all individual faculty
379 members, the KCF ~~with and~~ the program director are
380 responsible for the planning, implementation, monitoring
381 and evaluation of the fellows' clinical and research ~~training~~
382 education.
383

384 II.B.7.b).(2) ~~The majority of~~ At least 50% of the KCF must demonstrate
385 evidence of productivity in ~~the~~ scholarship, specifically,
386 peer-reviewed funding; publication of original research,
387 review articles, editorials, or case reports in peer-reviewed
388 journals; or chapters in textbooks. ~~as defined in II.B.5.b.(1),~~
389 or (2) above
390

391 II.B.7.b).(3) At least one KCF must:
392

393 II.B.7.b).(3).(a) be knowledgeable in the evaluation and
394 assessment of the ACGME competencies; and,
395

396 II.B.7.b).(3).(b) spend significant time in the evaluation of fellows,
397 including the direct observation of fellows with
398 patients.
399

400 II.B.7.b).(4) Appointment of one KCF to be an associate program
401 director is suggested.
402

403 II.B.8. ~~All~~ Clinical faculty members should participate in ~~prescribed~~ faculty
404 development programs designed to enhance the effectiveness of their
405 teaching.

- 406
407 **II.C. Other Program Personnel**
408
409 **The institution and the program must jointly ensure the availability of all**
410 **necessary professional, technical, and clerical personnel for the effective**
411 **administration the program.**
412
413 *II.C.1. There must be services available from other health care professionals,*
414 *including dietitians, language interpreters, nurses, occupational*
415 *therapists, physical therapists, and social workers.*
416
417 *II.C.2. There must be ~~the availability of~~ appropriate and timely consultation from*
418 *other specialties.*
419
420 **II.D. Resources**
421
422 **The institution and the program must jointly ensure the availability of**
423 **adequate resources for fellow education, as defined in the specialty**
424 **program requirements.**
425
426 *II.D.1. Space and Equipment*
427
428 *There must be space and equipment for the ~~educational~~ program,*
429 *including meeting rooms, ~~classrooms~~, examination rooms, computers,*
430 *visual and other educational aids, and work/study space.*
431
432 *II.D.2. Facilities*
433
434 *II.D.2.a) Inpatient and outpatient systems must be in place to prevent*
435 *fellows from performing routine clerical functions, including*
436 *scheduling tests and appointments, and retrieving records and*
437 *letters.*
438
439 *II.D.2.b) The sponsoring institution must provide the broad range of*
440 *facilities and clinical support services required to provide*
441 *comprehensive care of adult patients. ~~Fellows must have clinical~~*
442 *~~experiences in efficient, effective ambulatory and inpatient care~~*
443 *~~settings.~~*
444
445 *II.D.2.c) Fellows must have access to a lounge facility during assigned*
446 *duty hours.*
447
448 *II.D.2.d) When fellows are ~~assigned night duty~~ in the hospital, assigned*
449 *night duty, or called in from home, they must be provided with ~~on-~~*
450 *~~call facilities that are convenient and that afford privacy, safety,~~*
451 *~~and a restful environment with~~ a secure space for their*
452 *belongings.*
453
454 *II.D.2.e) A pulmonary function testing laboratory must be available*
455
456 *II.D.2.f) A bronchoscopy suite, including appropriate space and staffing for*

- 457 pulmonary procedure must be available.
 458
 459 II.D.2.g) Critical care, postoperative care, and respiratory care services_
 460 must be available.
 461
 462 II.D.3. Laboratory and Imaging Services
 463
 464 The following must be available at the primary clinical site:
 465
 466 II.D.3.a) a supporting laboratory ~~must be available~~ to provide complete and
 467 prompt laboratory evaluation;
 468
 469 II.D.3.b) timely bedside imaging services ~~must be available to~~ for patients
 470 in the critical care units; and,
 471
 472 II.D.3.c) computed tomography (CT) imaging, including CT angiography-
 473 ~~must be available; and~~
 474
 475 II.D.3.d) ~~which may be located at an institution other than the primary-~~
 476 ~~training site must be available.~~
 477
 478 II.D.4. Other Facilities, Resources, or Support Services
 479
 480 The following must be available:
 481
 482 II.D.4.a) pathology services, including exfoliate cytology; ~~must be available.~~
 483
 484 II.D.4.b) a thoracic surgery service; ~~must be available.~~
 485
 486 II.D.4.c) a laboratory for sleep-related breathing disorders; and,
 487
 488 II.D.4.d) ~~A close liaison with~~ other services, including radiology, pathology,
 489 microbiology, laboratory medicine, occupational medicine,
 490 immunology, physical medicine, and rehabilitation, otolaryngology,
 491 and anesthesiology ~~services should be available.~~
 492
 493 II.D.5. *Medical Records*
 494
 495 *Access to an electronic health record should be provided. In the absence*
 496 *of an existing electronic health record, institutions must demonstrate*
 497 *institutional commitment to its development and progress toward its*
 498 *implementation.*
 499
 500 II.D.6. Patient Population
 501
 502 II.D.6.a) The patient population must have a variety of clinical problems
 503 and stages of diseases.
 504
 505 II.D.6.b) There must be patients of each gender both sexes, with a broad
 506 age range, including geriatric patients.
 507

- 508 II.D.6.c) *A sufficient number of patients must be available to enable ensure*
509 *adequate inpatient and ambulatory experience for each fellow to*
510 *achieve the required educational outcomes.*
- 511
- 512 II.D.6.d) *Provide* There must be an average daily census of at least five
513 patients per fellow during assignments to critical care units.
- 514
- 515 **II.E. Medical Information Access**
- 516
- 517 **Fellows must have ready access to specialty-specific and other appropriate**
518 **reference material in print or electronic format. Electronic medical literature**
519 **databases with search capabilities should be available.**
- 520
- 521 **III. Fellow Appointments**
- 522
- 523 **III.A. Eligibility Criteria**
- 524
- 525 **The program director must comply with the criteria for fellow eligibility as**
526 **specified in the Institutional Requirements.**
- 527
- 528 III.A.1. *Prior to appointment in the fellowship ~~program~~, fellows ~~appointed~~ should*
529 *have completed an ACGME-accredited internal medicine ~~education~~*
530 *~~program.~~*
- 531
- 532 III.A.2. *Fellows from non-ACGME-~~accredited~~ internal medicine ~~education~~*
533 *programs must have at least three years of internal medicine education*
534 *prior to starting the fellowship.*
- 535
- 536 III.A.3. *When averaged over any five-year period, a minimum of 75% of fellows in*
537 *each ~~subspecialty training~~ program must be graduates of an ACGME-*
538 *accredited internal medicine ~~training~~ program. ~~Non-ACGME internal~~*
539 *medicine ~~trained~~ ~~educated~~ fellows must have at least three years of*
540 *internal medicine ~~training~~ prior to starting fellowship.*
- 541
- 542 III.A.4. *The program director must inform ~~non-ACGME trained~~ applicants from*
543 *non-ACGME-accredited programs, prior to appointment and in writing, of*
544 *the ABIM policies and procedures that ~~may~~ will affect the fellow's their*
545 *eligibility for ABIM certification.*
- 546
- 547 **III.B. Number of Fellows**
- 548
- 549 **The program director may not appoint more fellows than approved by the**
550 **Review Committee, unless otherwise stated in the specialty-specific**
551 **requirements. The program's educational resources must be adequate to**
552 **support the number of fellows appointed to the program.**
- 553
- 554 III.B.1. *The ~~minimum~~ number of available fellow positions in the ~~training~~ program*
555 *must be at least one per year ~~not be less than the number of accredited~~*
556 *~~training years in the program.~~*
- 557
- 558 **III.C. Fellow Transfers**

- 559
560 **III.C.1.** Before accepting a fellow who is transferring from another program,
561 the program director must obtain written or electronic verification of
562 previous educational experiences and a summative competency-
563 based performance evaluation of the transferring fellow.
564
- 565 **III.C.2.** A program director must provide timely verification of fellowship
566 education and summative performance evaluations for fellows who
567 leave the program prior to completion.
568
- 569 **III.D.** Appointment of Fellows and Other Learners
570
- 571 The presence of other learners (including, but not limited to, residents from
572 other specialties, subspecialty fellows, PhD students, and nurse
573 practitioners) in the program must not interfere with the appointed fellows'
574 education. The program director must report the presence of other learners
575 to the DIO and GMEC in accordance with sponsoring institution guidelines.
576
- 577 **IV. Educational Program**
578
- 579 **IV.A.** The curriculum must contain the following educational components:
580
- 581 **IV.A.1.** Overall educational goals for the program, which the program must
582 distribute to fellows and faculty annually;
583
- 584 **IV.A.2.** Competency-based goals and objectives for each assignment at
585 each educational level, which the program must distribute to fellows
586 and faculty annually, in either written or electronic form. These
587 should be reviewed by the fellow at the start of each rotation;
588
- 589 **IV.A.3.** Regularly scheduled didactic sessions; and,
590
- 591 *IV.A.3.a) The core curriculum must include a didactic program based upon*
592 *the core knowledge content in the subspecialty area.*
593
- 594 *IV.A.3.a).(1) The program must afford each fellow an opportunity to*
595 *review topics covered in conferences that he or she was*
596 *unable to attend.*
597
- 598 *IV.A.3.a).(2) Fellows must participate in clinical case conferences,*
599 *journal clubs, research conferences, and morbidity and*
600 *mortality or quality improvement conferences.*
601
- 602 *IV.A.3.a).(3) All core conferences must have at least one faculty*
603 *member present, and must be scheduled as to ensure*
604 *peer-peer and peer-faculty interaction.*
605
- 606 *IV.A.3.b) Patient-based teaching must include direct interaction between*
607 *fellows and attendingsfaculty members, bedside teaching,*
608 *discussion of pathophysiology, and the use of current evidence in*
609 *diagnostic and therapeutic decisions. The teaching must be:*

610		
611	IV.A.3.b).(1)	<i>formally conducted on all inpatient, outpatient, and</i>
612		<i>consultative services; and,</i>
613		
614	IV.A.3.b).(2)	<i>conducted with a frequency and duration <u>sufficient to that</u></i>
615		<i>ensures a meaningful and continuous teaching relationship</i>
616		<i>between the assigned <u>supervising faculty member(s)</u></i>
617		<i>teaching attending and fellows.</i>
618		
619	IV.A.3.c)	<u><i>Fellows must receive instruction in practice management relevant</i></u>
620		<u><i>to pulmonary disease.</i></u>
621		
622	IV.A.4.	Delineation of fellow responsibilities for patient care, progressive
623		responsibility for patient management, and supervision of fellows
624		over the continuum of the program.
625		
626	IV.A.5.	ACGME Competencies
627		
628		The program must integrate the following ACGME competencies
629		into the curriculum:
630		
631	IV.A.5.a)	Patient Care
632		
633		Fellows must be able to provide patient care that is
634		compassionate, appropriate, and effective for the treatment of
635		health problems and the promotion of health. Fellows:
636		
637	IV.A.5.a).(1)	<u><i>must demonstrate competence in the practice of health</i></u>
638		<u><i>promotion, disease prevention, diagnosis, care, and</i></u>
639		<u><i>treatment of men and women patients of each gender,</i></u>
640		<u><i>from adolescence to old age, during health and all stages</i></u>
641		<u><i>of illness;</i></u>
642		
643	IV.A.5.a).(2)	must demonstrate competence in prevention, evaluation,
644		and management of patients with the following:
645		
646	IV.A.5.a).(2).(a)	acute lung injury, including radiation, inhalation,
647		and trauma;
648		
649	IV.A.5.a).(2).(b)	circulatory failure;
650		
651	IV.A.5.a).(2).(c)	diffuse interstitial lung disease;
652		
653	IV.A.5.a).(2).(d)	disorders of the pleura and the mediastinum;
654		
655	IV.A.5.a).(2).(e)	iatrogenic respiratory diseases, including drug
656		induced disease;
657		
658	IV.A.5.a).(2).(f)	obstructive lung diseases, including asthma,
659		bronchitis, emphysema, bronchiectasis;
660		

661	IV.A.5.a).(2).(g)	occupational and environmental lung diseases;
662		
663	IV.A.5.a).(2).(h)	pulmonary embolism and pulmonary embolic disease;
664		
665		
666	IV.A.5.a).(2).(i)	pulmonary infections, including tuberculous, fungal, and those <u>infections</u> in the immunocompromised host (e.g., HIV-related infections);
667		
668		
669		
670	IV.A.5.a).(2).(j)	pulmonary malignancy -- primary and metastatic;
671		
672	IV.A.5.a).(2).(k)	pulmonary manifestations of systemic diseases, including collagen vascular disease and diseases that are primary in other organs;
673		
674		
675		
676	IV.A.5.a).(2).(l)	pulmonary vascular disease, including primary and secondary pulmonary hypertension and the vasculitis and pulmonary hemorrhage syndromes;
677		
678		
679		
680	IV.A.5.a).(2).(m)	respiratory failure, including the acute respiratory distress syndrome, acute and chronic respiratory failure in obstructive lung diseases, and neuromuscular respiratory drive disorders; and,
681		
682		
683		
684		
685	IV.A.5.a).(2).(n)	sleep-disordered breathing.
686		
687	IV.A.5.a).(3)	The program must be structured to permit all fellows to develop <u>must demonstrate competence requisite</u> procedural, technical skills and other skills, including the ability to <u>in</u> interpreting data derived from various bedside devices commonly employed to monitor patients, the interpretation of <u>as well as data from</u> laboratory studies related to sputum, bronchopulmonary secretions, <u>and</u> pleural fluid;
688		
689		
690		
691		
692		
693		
694		
695		
696	IV.A.5.a).(4)	Fellows must demonstrate competence in <u>procedural and technical skills, including:</u>
697		
698		
699	IV.A.5.a).(4).(a)	airway management;
700		
701	IV.A.5.a).(4).(b)	the use of a variety of positive pressure ventilatory modes, including:
702		
703		
704	IV.A.5.a).(4).(b).(i)	initiation and maintenance, and weaning of ventilatory support;
705		
706		
707	IV.A.5.a).(4).(b).(ii)	respiratory care techniques; and,
708		
709	IV.A.5.a).(4).(b).(iii)	withdrawal of mechanical ventilatory support.
710		
711		

- 712 IV.A.5.a).(4).(c) ~~the~~ use of reservoir masks and continuous positive
713 airway pressure masks for delivery of supplemental
714 oxygen, humidifiers, nebulizers, and incentive
715 spirometry;
- 716
- 717 IV.A.5.a).(4).(d) flexible fiber-optic bronchoscopy procedures
718 including those where endobronchial and
719 transbronchial biopsies and transbronchial needle
720 aspiration are performed (each fellow must perform
721 a minimum of 50-100 such procedures);
- 722
- 723 IV.A.5.a).(4).(e) pulmonary function tests to assess respiratory
724 mechanics and gas exchange, including
725 spirometry, flow volume studies, lung volumes,
726 diffusing capacity, arterial blood gas analysis,
727 exercise studies, and interpretation of the results of
728 bronchoprovocation testing using methacholine or
729 histamine;
- 730
- 731 IV.A.5.a).(4).(f) diagnostic and therapeutic procedures, including
732 thoracentesis, endotracheal intubation, and related
733 procedures;
- 734
- 735 IV.A.5.a).(4).(g) use of chest tubes and drainage systems;
- 736
- 737 IV.A.5.a).(4).(h) insertion of arterial, central venous, and pulmonary
738 artery balloon flotation catheters;
- 739
- 740 IV.A.5.a).(4).(i) operation of bedside hemodynamic monitoring
741 systems;
- 742
- 743 IV.A.5.a).(4).(j) emergency cardioversion;
- 744
- 745 IV.A.5.a).(4).(k) use of ultrasound techniques to perform
746 thoracentesis and place intravascular and
747 intracavitary tubes and catheters; and,
- 748
- 749 IV.A.5.a).(4).(l) use of transcutaneous pacemakers.

751 **IV.A.5.b)**

Medical Knowledge

752
753 **Fellows must demonstrate knowledge of established and**
754 **evolving biomedical, clinical, epidemiological and social-**
755 **behavioral sciences, as well as the application of this**
756 **knowledge to patient care. Fellows:**

- 757
- 758 IV.A.5.b).(1) ~~are expected to learn~~ must demonstrate knowledge of the
759 scientific method of problem solving and evidence-based
760 decision making, a commitment to lifelong learning, and an
761 attitude of caring that is derived from humanistic and
762 professional values.;

763
764 IV.A.5.b).(2) *must ~~develop~~ demonstrate knowledge understanding of*
765 *indications, contraindications, limitations, complications,*
766 *techniques, and interpretation of results of those diagnostic*
767 *and therapeutic procedures integral to the discipline,*
768 *including the appropriate indication for and use of*
769 *screening tests/procedures;*
770
771 IV.A.5.b).(3) ~~are expected to~~ must demonstrate knowledge of-
772 ~~appropriate to the practice of pulmonary disease in each of~~
773 ~~the following areas:~~
774
775 IV.A.5.b).(3).(a) ~~the scientific method of problem solving, evidence-~~
776 ~~based decision making, a commitment to lifelong-~~
777 ~~learning, and an attitude of caring that is derived-~~
778 ~~from humanistic and professional values.~~
779
780 IV.A.5.b).(3).(b) imaging techniques commonly employed in the
781 evaluation of patients with pulmonary diseases or
782 critical illness, including the use of ultrasound;
783
784 IV.A.5.b).(3).(c) the basic sciences, with particular emphasis on:
785
786 IV.A.5.b).(3).(c).(i) genetics and molecular biology as they
787 relate to pulmonary diseases;
788
789 IV.A.5.b).(3).(c).(ii) developmental biology;
790
791 IV.A.5.b).(3).(c).(iii) pulmonary physiology and pathophysiology
792 in systemic diseases; and,
793
794 IV.A.5.b).(3).(c).(iv) biochemistry and physiology, including cell
795 and molecular biology and immunology, as
796 they relate to pulmonary disease.
797
798 IV.A.5.b).(3).(d) indications, complications, and outcomes of lung
799 transplantation;
800
801 IV.A.5.b).(3).(e) recognition and management of the critically-ill from
802 disasters, including those disasters caused by
803 chemical and biological agents;
804
805 IV.A.5.b).(3).(f) the psychosocial and emotional effects of critical
806 illness on patients and their families; and,
807
808 IV.A.5.b).(3).(g) the ethical, economic and legal aspects of critical
809 illness.

810
811 **IV.A.5.c)**

Practice-based Learning and Improvement

Fellows must demonstrate the ability to investigate and

814 evaluate their care of patients, to appraise and assimilate
815 scientific evidence, and to continuously improve patient care
816 based on constant self-evaluation and life-long learning.
817 Fellows are expected to develop skills and habits to be able
818 to meet the following goals:

819
820 **IV.A.5.c).(1)** identify strengths, deficiencies, and limits in one's
821 knowledge and expertise;

822
823 **IV.A.5.c).(2)** set learning and improvement goals;

824
825 **IV.A.5.c).(3)** identify and perform appropriate learning activities;

826
827 **IV.A.5.c).(4)** systematically analyze practice, using quality
828 improvement methods, and implement changes with
829 the goal of practice improvement;

830
831 **IV.A.5.c).(5)** incorporate formative evaluation feedback into daily
832 practice;

833
834 **IV.A.5.c).(6)** locate, appraise, and assimilate evidence from
835 scientific studies related to their patients' health
836 problems;

837
838 **IV.A.5.c).(7)** use information technology to optimize learning;

839
840 **IV.A.5.c).(8)** participate in the education of patients, families,
841 students, fellows and other health professionals; and,

842
843 *IV.A.5.c).(9)* obtain procedure-specific informed consent by competently
844 educating patients about rationale, technique, and
845 complications of procedures.

846
847 **IV.A.5.d)** **Interpersonal and Communication Skills**

848
849 **Fellows must demonstrate interpersonal and communication**
850 **skills that result in the effective exchange of information and**
851 **collaboration with patients, their families, and health**
852 **professionals. Fellows are expected to:**

853
854 **IV.A.5.d).(1)** communicate effectively with patients, families, and
855 the public, as appropriate, across a broad range of
856 socioeconomic and cultural backgrounds;

857
858 **IV.A.5.d).(2)** communicate effectively with physicians, other health
859 professionals, and health related agencies;

860
861 **IV.A.5.d).(3)** work effectively as a member or leader of a health care
862 team or other professional group;

863

- 864 **IV.A.5.d).(4)** act in a consultative role to other physicians and
865 health professionals; and,
866
867 **IV.A.5.d).(5)** maintain comprehensive, timely, and legible medical
868 records, if applicable.

869
870 **IV.A.5.e)** **Professionalism**

871
872 **Fellows must demonstrate a commitment to carrying out**
873 **professional responsibilities and an adherence to ethical**
874 **principles. Fellows are expected to demonstrate:**

- 875
876 **IV.A.5.e).(1)** compassion, integrity, and respect for others;
877
878 **IV.A.5.e).(2)** responsiveness to patient needs that supersedes self-
879 interest;
880
881 **IV.A.5.e).(3)** respect for patient privacy and autonomy;
882
883 **IV.A.5.e).(4)** accountability to patients, society and the profession;
884
885 **IV.A.5.e).(5)** sensitivity and responsiveness to a diverse patient
886 population, including but not limited to diversity in
887 gender, age, culture, race, religion, disabilities, and
888 sexual orientation;
889
890 **IV.A.5.e).(6)** high standards of ethical behavior, including maintaining
891 appropriate professional boundaries and relationships with
892 other physicians and other health care team members, and
893 avoiding conflicts of interest; and,
894
895 **IV.A.5.e).(7)** *a commitment to lifelong learning, and an attitude of caring*
896 *derived from humanistic and professional values.*

897
898 **IV.A.5.f)** **Systems-based Practice**

899
900 **Fellows must demonstrate an awareness of and**
901 **responsiveness to the larger context and system of health**
902 **care, as well as the ability to call effectively on other**
903 **resources in the system to provide optimal health care.**
904 **Fellows are expected to:**

- 905
906 **IV.A.5.f).(1)** work effectively in various health care delivery
907 settings and systems relevant to their clinical
908 specialty;
909
910 **IV.A.5.f).(2)** coordinate patient care within the health care system
911 relevant to their clinical specialty;
912
913 **IV.A.5.f).(3)** incorporate considerations of cost awareness and

- 914 **risk-benefit analysis in patient and/or population-**
915 **based care as appropriate;**
916
917 **IV.A.5.f).(4) advocate for quality patient care and optimal patient**
918 **care systems;**
919
920 **IV.A.5.f).(5) work in interprofessional teams to enhance patient**
921 **safety and improve patient care quality;**
922
923 **IV.A.5.f).(6) participate in identifying system errors and**
924 **implementing potential systems solutions;**
925
926 IV.A.5.f).(7) acquire skills required to organize, administer, and direct a
927 critical care unit; and,
928
929 IV.A.5.f).(8) acquire the skills required to organize, administer, and
930 direct a respiratory therapy section.
931
932 IV.A.6. Curriculum Organization and Fellow Experiences
933
934 IV.A.6.a) A minimum of 12 months must be devoted to clinical experience.
935
936 IV.A.6.a).(1) At least three months of training must be spent in the
937 medical intensive care unit (MICU).
938
939 IV.A.6.a).(2) At least nine months must be spent in non-critical care
940 pulmonary disease rotations.
941
942 IV.A.6.a).(3) 18 months of clinical experience is strongly suggested.
943
944 *IV.A.6.b) Fellows must participate in training using simulation.*
945
946 IV.A.6.c) ~~There should be an educational emphasis on pulmonary-~~
947 ~~physiology and its correlation with clinical disorders;~~
948
949 IV.A.6.d) Fellows must have ~~formal instruction and~~ clinical experience in the
950 evaluation and management of patients:
951
952 IV.A.6.d).(1) with genetic and developmental disorders of the
953 respiratory system, including cystic fibrosis; and,
954
955 IV.A.6.d).(2) in pulmonary rehabilitation. ~~and~~
956
957 IV.A.6.e) Fellows must have clinical experience in examination and
958 interpretation of lung tissue for infectious agents, cytology, and
959 histopathology.
960
961 IV.A.6.f) Fellows must acquire knowledge regarding monitoring and
962 supervising special services, including:
963
964 IV.A.6.f).(1) respiratory care units;

965		
966	IV.A.6.f).(2)	respiratory care techniques and services; and,
967		
968	IV.A.6.f).(3)	pulmonary function laboratories including quality control,
969		quality assurance and proficiency standards.
970		
971	IV.A.6.g)	Fellows must be given opportunities to assume continuing
972		responsibility for both acutely_ and chronically-ill patients, in order
973		to learn both the natural history of pulmonary disease, as well as
974		<u>and</u> the effectiveness of therapeutic programs.
975		
976	IV.A.6.h)	Experience with Continuity Ambulatory Patients
977		
978		Fellows must have a continuity ambulatory clinic experience to
979		develop a continuous healing relationship with patients for whom
980		they provide subspecialty care. This continuity experience should
981		<u>that</u> exposes <u>fellows</u> them to the breadth and depth of the
982		subspecialty.
983		
984	IV.A.6.h).(1)	This experience should average one half-day each week.
985		
986	IV.A.6.h).(2)	Overall <i>This experience must include an appropriate</i>
987		<i>distribution of patients of both <u>each</u> genders and a diversity</i>
988		<i>of ages, <u>which</u>. This should be accomplished by <u>through</u></i>
989		<i>either:</i>
990		
991	IV.A.6.h).(2).(a)	<i>a continuity clinic which provides fellows the</i>
992		<i>opportunity to observe and learn the course of</i>
993		<i>disease; or,</i>
994		
995	IV.A.6.h).(2).(b)	<i>selected blocks of at least six months which</i>
996		<i>address specific areas of pulmonary disease.</i>
997		
998	IV.A.6.h).(3)	<i>Each fellow should, on average, be responsible for four to</i>
999		<i>eight patients during each half-day session.</i>
1000		
1001	IV.A.6.h).(4)	The continuing patient care experience should not be
1002		interrupted by more than one month, excluding a fellow's
1003		vacation.
1004		
1005	IV.A.6.h).(5)	<u>Up to six months may be exempted from ambulatory</u>
1006		<u>experiences during MICU rotations, other time-intensive</u>
1007		<u>rotations, or vacation.</u>
1008		
1009	IV.A.6.h).(6)	It is suggested that Fellows should be informed of the
1010		status of their continuity patients when they <u>such</u> patients
1011		are hospitalized, <u>as clinically appropriate</u> so the fellows
1012		can make appropriate arrangements to maintain continuity
1013		of care.
1014		
1015	IV.A.6.i)	Procedures and Technical Skills

1016		
1017	IV.A.6.i).(1)	<i>Direct faculty supervision of procedures performed by each fellow must occur until proficiency has been acquired and documented by the program director.</i>
1018		
1019		
1020		
1021	IV.A.6.i).(2)	A skilled preceptor <u>Faculty members must be available to teach and supervise the fellows in the performance and interpretation of these procedures.</u> Procedures which must be documented in each fellow's record, including indications, outcomes, diagnoses, and supervisor(s).
1022		
1023		
1024		
1025		
1026		
1027	IV.A.6.j)	The Fellows must have experience <u>be given opportunities to function</u> in the role of a pulmonary disease consultant in both the inpatient and outpatient settings.
1028		
1029		
1030		
1031	IV.B.	Fellows' Scholarly Activities
1032		
1033	IV.B.1.	The curriculum must advance fellows' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.
1034		
1035		
1036		
1037	IV.B.2.	Fellows should participate in scholarly activity.
1038		
1039	<i>IV.B.2.a)</i>	<i>The majority of fellows must demonstrate evidence of <u>scholarship</u> recent research productivity conducted during the fellowship through <u>one or more of the following</u>:</i>
1040		
1041		
1042		
1043	<i>IV.B.2.a).(1)</i>	<i><u>publication of articles, book chapters, abstracts, or case reports in peer-reviewed journals;</u></i>
1044		
1045		
1046	<i>IV.B.2.a).(2)</i>	<i><u>publication of peer-reviewed performance improvement or education research;</u></i>
1047		
1048		
1049	<i>IV.B.2.a).(3)</i>	<i><u>peer-reviewed funding; or,</u></i>
1050		
1051	<i>IV.B.2.a).(4)</i>	<i><u>peer-reviewed abstracts presented at regional, state, or national specialty meetings.</u></i>
1052		
1053		
1054	IV.B.3.	The sponsoring institution and program should allocate adequate educational resources to facilitate fellow involvement in scholarly activities.
1055		
1056		
1057	V.	Evaluation
1058		
1059	V.A.	Fellow
1060		
1061	V.A.1.	Formative Evaluation
1062		
1063	V.A.1.a)	The faculty must evaluate fellow performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.
1064		
1065		
1066		

1067		
1068	V.A. 1.a).(1)	<i>The faculty must discuss this evaluation with the <u>each</u> fellow at the completion of the <u>each</u> assignment.</i>
1069		
1070		
1071	V.A. 1.a).(2)	<i><u>Assessment of procedural competence should include a formal evaluation process and not be based solely on a minimum number of procedures performed.</u></i>
1072		
1073		
1074		
1075	V.A.1.b)	The program must:
1076		
1077	V.A.1.b).(1)	provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;
1078		
1079		
1080		
1081		
1082		
1083	V.A. 1.b).(1).(a)	<i><u>Patient Care</u></i>
1084		
1085		
1086		<i><u>The program must assess each fellow in data gathering, clinical reasoning, patient management, and procedures in both the inpatient and outpatient setting. This assessment must involve direct observation of fellow-patient encounters.</u></i>
1087		
1088		
1089		
1090		
1091	V.A. 1.b).(1).(a).(i)	<i><u>Each program must define a standard criteria for proficiency <u>competence</u> for all required and elective procedures.</u></i>
1092		
1093		
1094		
1095	V.A. 1.b).(1).(a).(ii)	<i><u>The record of evaluation must include the fellow's logbook or an equivalent method to demonstrate that each fellow has achieved competence in the performance of required procedures.</u></i>
1096		
1097		
1098		
1099		
1100		
1101	V.A. 1.b).(1).(b)	<i><u>Medical Knowledge</u></i>
1102		
1103		
1104		<i><u>The program must use an objective formative assessment method. The same formative assessment method must be administered at least twice during the program.</u></i>
1105		
1106		
1107		
1108	V.A. 1.b).(1).(c)	<i><u>Practice-based Learning and Improvement</u></i>
1109		
1110		<i><u>The program must use performance data to assess each fellow in:</u></i>
1111		
1112		
1113	V.A. 1.b).(1).(c).(i)	<i><u>application of evidence to patient care;</u></i>
1114		
1115	V.A. 1.b).(1).(c).(ii)	<i><u>practice improvement;</u></i>
1116		
1117	V.A. 1.b).(1).(c).(iii)	<i><u>teaching skills involving peers and patients;</u></i>

1118		<u>and.</u>
1119		
1120	V.A. 1.b).(1).(c).(iv)	<u>scholarship.</u>
1121		
1122	V.A. 1.b).(1).(d)	<u>Interpersonal and Communication Skills</u>
1123		
1124		<u>The program must use both direct observation and</u>
1125		<u>multi-source evaluation, including patients, peers</u>
1126		<u>and non-physician team members, to assess each</u>
1127		<u>fellow's performance in:</u>
1128		
1129	V.A. 1.b).(1).(d).(i)	<u>communication with patient and family;</u>
1130		
1131	V.A. 1.b).(1).(d).(ii)	<u>teamwork;</u>
1132		
1133	V.A. 1.b).(1).(d).(iii)	<u>communication with peers, including</u>
1134		<u>transitions in care; and,</u>
1135		
1136	V.A. 1.b).(1).(d).(iv)	<u>record keeping.</u>
1137		
1138	V.A. 1.b).(1).(e)	<u>Professionalism</u>
1139		
1140		<u>The program must use multi-source evaluation,</u>
1141		<u>including patients, peers, and non-physician team</u>
1142		<u>members, to assess each fellow's:</u>
1143		
1144	V.A. 1.b).(1).(e).(i)	<u>honesty and integrity;</u>
1145		
1146	V.A. 1.b).(1).(e).(ii)	<u>ability to meet professional responsibilities;</u>
1147		
1148	V.A. 1.b).(1).(e).(iii)	<u>ability to maintain appropriate professional</u>
1149		<u>relationships with patients and colleagues;</u>
1150		<u>and,</u>
1151		
1152	V.A. 1.b).(1).(e).(iv)	<u>commitment to self-improvement.</u>
1153		
1154	V.A. 1.b).(1).(f)	<u>Systems-based Practice</u>
1155		
1156		<u>The program must use multi-source evaluation,</u>
1157		<u>including peers, and non-physician team members,</u>
1158		<u>to assess each fellow's:</u>
1159		
1160	V.A. 1.b).(1).(f).(i)	<u>ability to provide care coordination,</u>
1161		<u>including transition of care;</u>
1162		
1163	V.A. 1.b).(1).(f).(ii)	<u>ability to work in interdisciplinary teams;</u>
1164		
1165	V.A. 1.b).(1).(f).(iii)	<u>advocacy for quality of care; and,</u>
1166		
1167	V.A. 1.b).(1).(f).(iv)	<u>ability to identify system problems and</u>
1168		<u>participate in improvement activities.</u>
1169		

- 1170 **V.A.1.b).(2)** use multiple evaluators (e.g., faculty, peers, patients,
1171 self, and other professional staff);
1172
- 1173 **V.A.1.b).(3)** document progressive fellow performance
1174 improvement appropriate to educational level; and
1175
- 1176 **V.A.1.b).(4)** provide each fellow with documented semiannual
1177 evaluation of performance with feedback.
1178
- 1179 **V.A.1.b).(4).(a)** *Fellows' performance in continuity clinic must be*
1180 *reviewed with them verbally and in writing at least*
1181 *semiannually.*
1182
- 1183 **V.A.1.c)** The evaluations of fellow performance must be accessible for
1184 review by the fellow, in accordance with institutional policy.
1185
- 1186 **V.A.2.** Summative Evaluation
1187
- 1188 The program director must provide a summative evaluation for each
1189 fellow upon completion of the program. This evaluation must
1190 become part of the fellow's permanent record maintained by the
1191 institution, and must be accessible for review by the fellow in
1192 accordance with institutional policy. This evaluation must:
1193
- 1194 **V.A.2.a)** document the fellow's performance during the final period of
1195 education; and,
1196
- 1197 **V.A.2.b)** verify that the fellow has demonstrated sufficient competence
1198 to enter practice without direct supervision.
1199
- 1200 **V.B.** Faculty Evaluation
1201
- 1202 **V.B.1.** At least annually, the program must evaluate faculty performance as
1203 it relates to the educational program.
1204
- 1205 **V.B.2.** These evaluations should include a review of faculty's clinical
1206 teaching abilities, commitment to the educational program, clinical
1207 knowledge, professionalism, and scholarly activities.
1208
- 1209 **V.B.3.** This evaluation must include at least annual written confidential
1210 evaluations by fellows.
1211
- 1212 **V.B.3.a)** *~~In addition,~~ Fellows must have the opportunity to provide*
1213 *confidential written evaluations of each ~~teaching-attending-~~*
1214 *supervising faculty member at the end of a each rotation.*
1215
- 1216 **V.B.3.b)** *~~The program director must be reviewed~~ These evaluations must*
1217 *be reviewed with each attending faculty member annually.*
1218
- 1219 **V.C.** Program Evaluation and Improvement

1220		
1221	V.C.1.	The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:
1222		
1223		
1224		
1225	V.C.1.a)	fellow performance;
1226		
1227	V.C.1.b)	faculty development;
1228		
1229	V.C.1.c)	graduate performance, including performance of program graduates on the certification examination; and,
1230		
1231		
1232	V.C.1.c).(1)	<i>At least 80% of <u>program's graduating fellows from those eligible to take an ABIM subspecialty certifying examination upon completion of their training for the most recently defined five year period who are eligible should must have taken an the 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).</u></i>
1233		
1234		
1235		
1236		
1237		
1238		
1239		
1240		
1241	V.C.1.c).(2)	<i>At least 80% of a program's graduates taking the ABIM certifying examination for the first time during the most recently defined five year period should pass.</i>
1242		
1243		
1244		
1245	V.C.1.d)	program quality. Specifically:
1246		
1247	V.C.1.d).(1)	Fellows and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually.
1248		
1249		
1250		
1251	V.C.1.d).(2)	The program must use the results of fellows' assessments of the program together with other program evaluation results to improve the program.
1252		
1253		
1254		
1255	V.C.1.d).(3)	<i>At least 80% of the entering fellows should have completed the program when averaged over a five-year period.</i>
1256		
1257		
1258		
1259	V.C.2.	If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.
1260		
1261		
1262		
1263		
1264		
1265	V.C.3.	<i>Representative program personnel, at a minimum to include the program director, representative faculty, and one fellow, must review program goals and objectives, and the effectiveness with which they are achieved.</i>
1266		
1267		
1268		
1269	VI. Fellow Duty Hours in the Learning and Working Environment	
1270		

- 1271 **VI.A. Professionalism, Personal Responsibility, and Patient Safety**
1272
1273 **VI.A.1. Programs and sponsoring institutions must educate fellows and**
1274 **faculty members concerning the professional responsibilities of**
1275 **physicians to appear for duty appropriately rested and fit to provide**
1276 **the services required by their patients.**
1277
1278 **VI.A.2. The program must be committed to and responsible for promoting**
1279 **patient safety and fellow well-being in a supportive educational**
1280 **environment.**
1281
1282 **VI.A.3. The program director must ensure that fellows are integrated and**
1283 **actively participate in interdisciplinary clinical quality improvement**
1284 **and patient safety programs.**
1285
1286 **VI.A.4. The learning objectives of the program must:**
1287
1288 **VI.A.4.a) be accomplished through an appropriate blend of supervised**
1289 **patient care responsibilities, clinical teaching, and didactic**
1290 **educational events; and,**
1291
1292 **VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill**
1293 **non-physician service obligations.**
1294
1295 ~~VI.A.4.b).(1) *Fellows' service responsibilities must be limited to patients*~~
1296 ~~*for whom the teaching service has diagnostic and*~~
1297 ~~*therapeutic responsibility.*~~
1298
1299 **VI.A.5. The program director and institution must ensure a culture of**
1300 **professionalism that supports patient safety and personal**
1301 **responsibility. Fellows and faculty members must demonstrate an**
1302 **understanding and acceptance of their personal role in the**
1303 **following:**
1304
1305 **VI.A.5.a) assurance of the safety and welfare of patients entrusted to**
1306 **their care;**
1307
1308 **VI.A.5.b) provision of patient- and family-centered care;**
1309
1310 **VI.A.5.c) assurance of their fitness for duty;**
1311
1312 **VI.A.5.d) management of their time before, during, and after clinical**
1313 **assignments;**
1314
1315 **VI.A.5.e) recognition of impairment, including illness and fatigue, in**
1316 **themselves and in their peers;**
1317
1318 **VI.A.5.f) attention to lifelong learning;**
1319
1320 **VI.A.5.g) the monitoring of their patient care performance improvement**

- 1321 indicators; and,
 1322
 1323 **VI.A.5.h)** honest and accurate reporting of duty hours, patient
 1324 outcomes, and clinical experience data.
 1325
 1326 **VI.A.6.** All fellows and faculty members must demonstrate responsiveness
 1327 to patient needs that supersedes self-interest. Physicians must
 1328 recognize that under certain circumstances, the best interests of the
 1329 patient may be served by transitioning that patient’s care to another
 1330 qualified and rested provider.
 1331
 1332 **VI.B. Transitions of Care**
 1333
 1334 **VI.B.1.** Programs must design clinical assignments to minimize the number
 1335 of transitions in patient care.
 1336
 1337 **VI.B.2.** Sponsoring institutions and programs must ensure and monitor
 1338 effective, structured hand-over processes to facilitate both
 1339 continuity of care and patient safety.
 1340
 1341 **VI.B.3.** Programs must ensure that fellows are competent in communicating
 1342 with team members in the hand-over process.
 1343
 1344 **VI.B.4.** The sponsoring institution must ensure the availability of schedules
 1345 that inform all members of the health care team of attending
 1346 physicians and fellows currently responsible for each patient’s care.
 1347
 1348 **VI.C. Alertness Management/Fatigue Mitigation**
 1349
 1350 **VI.C.1.** The program must:
 1351
 1352 **VI.C.1.a)** educate all faculty members and fellows to recognize the
 1353 signs of fatigue and sleep deprivation;
 1354
 1355 **VI.C.1.b)** educate all faculty members and fellows in alertness
 1356 management and fatigue mitigation processes; and,
 1357
 1358 **VI.C.1.c)** adopt fatigue mitigation processes to manage the potential
 1359 negative effects of fatigue on patient care and learning, such
 1360 as naps or back-up call schedules.
 1361
 1362 **VI.C.2.** Each program must have a process to ensure continuity of patient
 1363 care in the event that a fellow may be unable to perform his/her
 1364 patient care duties.
 1365
 1366 **VI.C.3.** The sponsoring institution must provide adequate sleep facilities
 1367 and/or safe transportation options for fellows who may be too
 1368 fatigued to safely return home.
 1369
 1370 **VI.D. Supervision of Fellows**

1371
1372 **VI.D.1.** In the clinical learning environment, each patient must have an
1373 identifiable, appropriately-credentialed and privileged attending
1374 physician (or licensed independent practitioner as approved by each
1375 Review Committee) who is ultimately responsible for that patient’s
1376 care.
1377
1378 **VI.D.1.a)** This information should be available to fellows, faculty
1379 members, and patients.
1380
1381 **VI.D.1.b)** Fellows and faculty members should inform patients of their
1382 respective roles in each patient’s care.
1383
1384 **VI.D.2.** The program must demonstrate that the appropriate level of
1385 supervision is in place for all fellows who care for patients.
1386
1387 Supervision may be exercised through a variety of methods. Some
1388 activities require the physical presence of the supervising faculty
1389 member. For many aspects of patient care, the supervising
1390 physician may be a more advanced resident or fellow. Other
1391 portions of care provided by the fellow can be adequately
1392 supervised by the immediate availability of the supervising faculty
1393 member or resident physician, either in the institution, or by means
1394 of telephonic and/or electronic modalities. In some circumstances,
1395 supervision may include post-hoc review of fellow-delivered care
1396 with feedback as to the appropriateness of that care.
1397
1398 **VI.D.3.** Levels of Supervision
1399
1400 To ensure oversight of fellow supervision and graded authority and
1401 responsibility, the program must use the following classification of
1402 supervision:
1403
1404 **VI.D.3.a)** Direct Supervision – the supervising physician is physically
1405 present with the fellow and patient.
1406
1407 **VI.D.3.b)** Indirect Supervision:
1408
1409 **VI.D.3.b).(1)** with direct supervision immediately available – the
1410 supervising physician is physically within the hospital
1411 or other site of patient care, and is immediately
1412 available to provide Direct Supervision.
1413
1414 **VI.D.3.b).(2)** with direct supervision available – the supervising
1415 physician is not physically present within the hospital
1416 or other site of patient care, but is immediately
1417 available by means of telephonic and/or electronic
1418 modalities, and is available to provide Direct
1419 Supervision.
1420

- 1421 **VI.D.3.c)** **Oversight – the supervising physician is available to provide**
1422 **review of procedures/encounters with feedback provided**
1423 **after care is delivered.**
1424
- 1425 **VI.D.4.** **The privilege of progressive authority and responsibility, conditional**
1426 **independence, and a supervisory role in patient care delegated to**
1427 **each fellow must be assigned by the program director and faculty**
1428 **members.**
1429
- 1430 **VI.D.4.a)** **The program director must evaluate each fellow’s abilities**
1431 **based on specific criteria. When available, evaluation should**
1432 **be guided by specific national standards-based criteria.**
1433
- 1434 **VI.D.4.b)** **Faculty members functioning as supervising physicians**
1435 **should delegate portions of care to fellows, based on the**
1436 **needs of the patient and the skills of the fellows.**
1437
- 1438 **VI.D.4.c)** **Senior residents or fellows should serve in a supervisory role**
1439 **of junior residents in recognition of their progress toward**
1440 **independence, based on the needs of each patient and the**
1441 **skills of the individual resident or fellow.**
1442
- 1443 **VI.D.5.** **Programs must set guidelines for circumstances and events in**
1444 **which fellows must communicate with appropriate supervising**
1445 **faculty members, such as the transfer of a patient to an intensive**
1446 **care unit, or end-of-life decisions.**
1447
- 1448 **VI.D.5.a)** **Each fellow must know the limits of his/her scope of**
1449 **authority, and the circumstances under which he/she is**
1450 **permitted to act with conditional independence.**
1451
- 1452 **VI.D.5.a).(1)** **In particular, PGY-1 residents should be supervised**
1453 **either directly or indirectly with direct supervision**
1454 **immediately available.**
1455
- 1456 **VI.D.6.** **Faculty supervision assignments should be of sufficient duration to**
1457 **assess the knowledge and skills of each fellow and delegate to**
1458 **him/her the appropriate level of patient care authority and**
1459 **responsibility.**
1460
- 1461 **VI.E.** **Clinical Responsibilities**
1462
- 1463 **The clinical responsibilities for each fellow must be based on PGY-level,**
1464 **patient safety, fellow education, severity and complexity of patient**
1465 **illness/condition and available support services.**
1466
- 1467 **VI.F.** **Teamwork**
1468
- 1469 **Fellows must care for patients in an environment that maximizes effective**
1470 **communication. This must include the opportunity to work as a member of**

1471		effective interprofessional teams that are appropriate to the delivery of care
1472		in the specialty.
1473		
1474	VI.G.	Fellow Duty Hours
1475		
1476	VI.G.1.	Maximum Hours of Work per Week
1477		
1478		Duty hours must be limited to 80 hours per week, averaged over a
1479		four-week period, inclusive of all in-house call activities and all
1480		moonlighting.
1481		
1482	VI.G.1.a)	Duty Hour Exceptions
1483		
1484		A Review Committee may grant exceptions for up to 10% or a
1485		maximum of 88 hours to individual programs based on a
1486		sound educational rationale.
1487		
1488		<i>The Review Committee for Internal Medicine will not consider</i>
1489		<i>requests for exceptions to the 80-hour limit to the fellows' work</i>
1490		<i>week.</i>
1491		
1492	VI.G.1.a).(1)	In preparing a request for an exception the program
1493		director must follow the duty hour exception policy
1494		from the ACGME Manual on Policies and Procedures.
1495		
1496	VI.G.1.a).(2)	Prior to submitting the request to the Review
1497		Committee, the program director must obtain approval
1498		of the institution's GMEC and DIO.
1499		
1500	VI.G.2.	Moonlighting
1501		
1502	VI.G.2.a)	Moonlighting must not interfere with the ability of the fellow
1503		to achieve the goals and objectives of the educational
1504		program.
1505		
1506	VI.G.2.b)	Time spent by fellows in Internal and External Moonlighting
1507		(as defined in the ACGME Glossary of Terms) must be
1508		counted towards the 80-hour Maximum Weekly Hour Limit.
1509		
1510	VI.G.2.c)	PGY-1 residents are not permitted to moonlight.
1511		
1512	VI.G.3.	Mandatory Time Free of Duty
1513		
1514		Fellows must be scheduled for a minimum of one day free of duty
1515		every week (when averaged over four weeks). At-home call cannot
1516		be assigned on these free days.
1517		
1518	VI.G.4.	Maximum Duty Period Length
1519		
1520	VI.G.4.a)	Duty periods of PGY-1 residents must not exceed 16 hours in

1521 duration.

1522

1523 **VI.G.4.b)** **Duty periods of PGY-2 residents and above may be**

1524 **scheduled to a maximum of 24 hours of continuous duty in**

1525 **the hospital. Programs must encourage fellows to use**

1526 **alertness management strategies in the context of patient**

1527 **care responsibilities. Strategic napping, especially after 16**

1528 **hours of continuous duty and between the hours of 10:00**

1529 **p.m. and 8:00 a.m., is strongly suggested.**

1530

1531 **VI.G.4.b).(1)** **It is essential for patient safety and fellow education**

1532 **that effective transitions in care occur. Fellows may be**

1533 **allowed to remain on-site in order to accomplish these**

1534 **tasks; however, this period of time must be no longer**

1535 **than an additional four hours.**

1536

1537 **VI.G.4.b).(2)** **Fellows must not be assigned additional clinical**

1538 **responsibilities after 24 hours of continuous in-house**

1539 **duty.**

1540

1541 **VI.G.4.b).(3)** **In unusual circumstances, fellows, on their own**

1542 **initiative, may remain beyond their scheduled period**

1543 **of duty to continue to provide care to a single patient.**

1544 **Justifications for such extensions of duty are limited**

1545 **to reasons of required continuity for a severely ill or**

1546 **unstable patient, academic importance of the events**

1547 **transpiring, or humanistic attention to the needs of a**

1548 **patient or family.**

1549

1550 **VI.G.4.b).(3).(a)** **Under those circumstances, the fellow must:**

1551

1552 **VI.G.4.b).(3).(a).(i)** **appropriately hand over the care of all**

1553 **other patients to the team responsible**

1554 **for their continuing care; and,**

1555

1556 **VI.G.4.b).(3).(a).(ii)** **document the reasons for remaining to**

1557 **care for the patient in question and**

1558 **submit that documentation in every**

1559 **circumstance to the program director.**

1560

1561 **VI.G.4.b).(3).(b)** **The program director must review each**

1562 **submission of additional service, and track**

1563 **both individual fellow and program-wide**

1564 **episodes of additional duty.**

1565

1566 **VI.G.5. Minimum Time Off between Scheduled Duty Periods**

1567

1568 **VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight**

1569 **hours, free of duty between scheduled duty periods.**

1570

1571	VI.G.5.b)	Intermediate-level residents have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.
1572		
1573		
1574		
1575		
1576		<u>Internal medicine subspecialty fellows are considered to be in the</u>
1577		<u>final years of education.</u>
1578		
1579	VI.G.5.c)	Residents in the final years of education be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.
1580		
1581		
1582		
1583		<u>Internal medicine subspecialty fellows are considered to be in the</u>
1584		<u>final years of education.</u>
1585		
1586	VI.G.5.c).(1)	This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that fellows in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these fellows must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.
1587		
1588		
1589		
1590		
1591		
1592		
1593		
1594		
1595	VI.G.5.c).(1).(a)	Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by fellows in their final years of education must be monitored by the program director.
1596		
1597		
1598		
1599		
1600		
1601	VI.G.5.c).(1).(b)	<u>In unusual circumstances, fellows may remain beyond their scheduled period of duty or return after their scheduled period of duty to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of the patient or family. Such episodes should be rare, must be of the fellows' own initiative, and need not initiate a new 'off-duty period' nor require a change in the scheduled 'off-duty period.'</u>
1602		
1603		
1604		
1605		
1606		
1607		
1608		
1609		
1610		
1611		
1612		
1613		
1614		
1615	VI.G.5.c).(1).(c)	<u>Under such circumstances, the fellow must appropriately hand over care of all other patients to the team responsible for their continuing care, and document the reasons for remaining or returning to care for the patient in question and submit that documentation to the program director.</u>
1616		
1617		
1618		
1619		
1620		
1621		

1622 VI.G.5.c).(1).(d) The program director must review each submission
1623 of additional service and track both individual
1624 fellows' and program-wide episodes of additional
1625 duty.
1626

1627 **VI.G.6. Maximum Frequency of In-House Night Float**
1628
1629 **Fellows must not be scheduled for more than six consecutive nights**
1630 **of night float.**
1631

1632 **VI.G.7. Maximum In-House On-Call Frequency**
1633
1634 **PGY-2 residents and above must be scheduled for in-house call no**
1635 **more frequently than every-third-night (when averaged over a four-**
1636 **week period).**
1637

1638 VI.G.7.a) *Internal Medicine ~~residency programs are~~ fellowships must not*
1639 *allowed to average in-house call over a four-week period.*
1640

1641 **VI.G.8. At-Home Call**
1642

1643 **VI.G.8.a) Time spent in the hospital by fellows on at-home call must**
1644 **count towards the 80-hour maximum weekly hour limit. The**
1645 **frequency of at-home call is not subject to the every-third-**
1646 **night limitation, but must satisfy the requirement for one-day-**
1647 **in-seven free of duty, when averaged over four weeks.**
1648

1649 **VI.G.8.a).(1) At-home call must not be so frequent or taxing as to**
1650 **preclude rest or reasonable personal time for each**
1651 **fellow.**
1652

1653 **VI.G.8.b) Fellows are permitted to return to the hospital while on at-**
1654 **home call to care for new or established patients. Each**
1655 **episode of this type of care, while it must be included in the**
1656 **80-hour weekly maximum, will not initiate a new "off-duty**
1657 **period".**
1658

1659 **VII. Innovative Projects**
1660
1661 **Requests for innovative projects that may deviate from the institutional, common**
1662 **and/or specialty specific program requirements must be approved in advance by**
1663 **the Review Committee. In preparing requests, the program director must follow**
1664 **Procedures for Approving Proposals for Innovative Projects located in the ACGME**
1665 **Manual on Policies and Procedures. Once a Review Committee approves a**
1666 **project, the sponsoring institution and program are jointly responsible for the**
1667 **quality of education offered to fellows for the duration of such a project.**
1668

1669 ***

1670 ACGME Approved: February 5, 2011 Effective: July 1, 2012
1671