

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Transplant Hepatology (Internal Medicine)**
3

4 **One-year 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 and fellowship programs are essential dimensions of the**
12 **transformation of the medical student to the independent practitioner along**
13 **the continuum of medical education. They are physically, emotionally, and**
14 **intellectually demanding, and require longitudinally-concentrated effort on**
15 **the part of the resident or fellow.**
16

17 **The specialty education of physicians to practice independently is**
18 **experiential, and necessarily occurs within the context of the health care**
19 **delivery system. Developing the skills, knowledge, and attitudes leading to**
20 **proficiency in all the domains of clinical competency requires the resident**
21 **and fellow physician to assume personal responsibility for the care of**
22 **individual patients. For the resident and fellow, the essential learning**
23 **activity is interaction with patients under the guidance and supervision of**
24 **faculty members who give value, context, and meaning to those**
25 **interactions. As residents and fellows gain experience and demonstrate**
26 **growth in their ability to care for patients, they assume roles that permit**
27 **them to exercise those skills with greater independence. This concept—**
28 **graded and progressive responsibility—is one of the core tenets of**
29 **American graduate medical education. Supervision in the setting of**
30 **graduate medical education has the goals of assuring the provision of safe**
31 **and effective care to the individual patient; assuring each resident’s and**
32 **fellow’s development of the skills, knowledge, and attitudes required to**
33 **enter the unsupervised practice of medicine; and establishing a foundation**
34 **for continued professional growth.**
35

36 **Int.B.4.** **Transplant hepatology is the study of the diseases leading to transplantation, the**
37 **evaluation of patients pre-transplant, the evaluation and treatment of the post-**
38 **transplant patient, and the management of the complications of transplantation.**
39 **Transplant hepatology fellowships provide advanced education to allow a fellow**
40 **to acquire competency in the subspecialty with sufficient expertise to act as an**
41 **independent consultant.**
42

43 **Int.A.2.C.** **The educational program in transplant hepatology ~~program~~ must be ~~one-year~~ 12**
44 **months in duration-length.**
45

46 **I. Institutions**

47
48 **I.A. Sponsoring Institution**
49

50 **One sponsoring institution must assume ultimate responsibility for the**
51 **program, as described in the Institutional Requirements, and this**

52 responsibility extends to fellow assignments at all participating sites.

53
54 The sponsoring institution and the program must ensure that the program
55 director has sufficient protected time and financial support for his or her
56 educational and administrative responsibilities to the program.
57

58 I.A.1. ~~A fellowship in~~ The transplant hepatology fellowship must function as an
59 integral part of an ACGME-accredited fellowship in gastroenterology
60 fellowship.

61
62 I.A.2. *The sponsoring institution must:*

63
64 I.A.2.a) ~~provide ensure~~ the program director with adequate support for the
65 administrative activities of the internal medicine subspecialty
66 program-fellowship.

67
68 I.A.2.a).(1) *The program director must not be required to generate*
69 *clinical or other income to provide this administrative*
70 *support.*

71
72 I.A.2.a).(2) *It is suggested this support be 25-50% of the program*
73 *director's salary, or protected time, depending on the size*
74 *of the program.*

75
76 I.A.3. *The sponsoring institution and participating sites must:*

77
78 I.A.3.a) demonstrate that there is a culture of continuous quality
79 improvement in the areas of patient care, patient safety, and
80 education;

81
82 I.A.3.b) demonstrate a commitment to quality patient-centered care and
83 safety, education, ~~research~~ and scholarship sufficient to support
84 the fellowship program; and,

85
86 I.A.3.c) share appropriate inpatient and outpatient faculty performance
87 data with the program director.

88
89 I.A.3.d) ~~provide fellow compensation, and benefits, faculty, facilities, and~~
90 ~~resources for education, clinical care, and research required for~~
91 ~~accreditation;~~

92
93 I.A.3.e) ~~notify the Review Committee within 60 days of changes in~~
94 ~~institutional governance, affiliation, or resources that affect the~~
95 ~~educational program as outlined in the Institutional Requirements;~~
96 ~~and~~

97
98 I.A.3.f) ~~provide at least one fellowship position; and~~

99
100 I.A.4. ~~Graduate education in the subspecialties of internal medicine requires a~~
101 ~~major commitment to education by the sponsoring institution.~~
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.**
137 **After approval, the program director must submit this change to the**
138 **ACGME via the ADS.**
139
140 **II.A.2. Qualifications of the program director must include:**
141
142 **II.A.2.a) requisite specialty expertise and documented educational**
143 **and administrative experience acceptable to the Review**
144 **Committee;**
145
146 **II.A.2.a).(1) The program director must have at least five years of**
147 **participation as an active faculty member in an ACGME-**
148 **accredited internal medicine residency, or gastroenterology**
149 **or transplant hepatology fellowship.**
150
151 **II.A.2.b) current certification in the subspecialty by the American**
152 **Board of Internal Medicine (ABIM), or subspecialty**
153 **qualifications that are acceptable to the Review Committee;**

- 154 and,
- 155
- 156 II.A.2.b).(1) The Review Committee only accepts current ABIM
- 157 certification in transplant hepatology.
- 158
- 159 II.A.2.c) current medical licensure and appropriate medical staff
- 160 appointment.
- 161
- 162 II.A.3. The program director must administer and maintain an educational
- 163 environment conducive to educating the fellows in each of the
- 164 ACGME competency areas. The program director must:
- 165
- 166 II.A.3.a) prepare and submit all information required and requested by
- 167 the ACGME;
- 168
- 169 II.A.3.b) be familiar with and oversee compliance with ACGME and
- 170 Review Committee policies and procedures as outlined in the
- 171 ACGME Manual of Policies and Procedures;
- 172
- 173 II.A.3.c) obtain review and approval of the sponsoring institution's
- 174 GMEC/DIO before submitting to the ACGME information or
- 175 requests for the following:
- 176
- 177 II.A.3.c).(1) all applications for ACGME accreditation of new
- 178 programs;
- 179
- 180 II.A.3.c).(2) changes in fellow complement;
- 181
- 182 II.A.3.c).(3) major changes in program structure or length of
- 183 training;
- 184
- 185 II.A.3.c).(4) progress reports requested by the Review Committee;
- 186
- 187 II.A.3.c).(5) responses to all proposed adverse actions;
- 188
- 189 II.A.3.c).(6) requests for increases or any change to fellow duty
- 190 hours;
- 191
- 192 II.A.3.c).(7) voluntary withdrawals of ACGME-accredited
- 193 programs;
- 194
- 195 II.A.3.c).(8) requests for appeal of an adverse action; and,
- 196
- 197 II.A.3.c).(9) appeal presentations to a Board of Appeal or the
- 198 ACGME.
- 199
- 200 II.A.3.d) obtain DIO review and co-signature on all program
- 201 information forms, as well as any correspondence or
- 202 document submitted to the ACGME that addresses:
- 203
- 204 II.A.3.d).(1) program citations; and/or,

- 205
206 **II.A.3.d).(2)** requests for changes in the program that would have
207 significant impact, including financial, on the program
208 or institution.
209
- 210 *II.A.3.e)* ensure that fellows' service responsibilities are limited to patients
211 for whom the teaching service has diagnostic and therapeutic
212 responsibility.
213
- 214 *II.A.3.f)* dedicate an average of 20 hours per week of his or her
215 professional effort to the ~~internal medicine subspecialty program~~
216 fellowship, including with sufficient time for administration of the
217 program; ~~and receive institutional support for that administrative~~
218 ~~time.~~
219
- 220 *II.A.3.g)* have a reporting relationship with the program director of the
221 gastroenterology program to ensure compliance with ~~the~~ ACGME
222 accreditation standards; and,
223
- 224 *II.A.3.h)* be available ~~located~~ at the primary principal clinical site.
225
- 226 **II.B. Faculty**
227
- 228 **II.B.1.** There must be a sufficient number of faculty with documented
229 qualifications to instruct and supervise all fellows.
230
- 231 **II.B.2.** The faculty must devote sufficient time to the educational program
232 to fulfill their supervisory and teaching responsibilities and
233 demonstrate a strong interest in the education of fellows.
234
- 235 **II.B.3.** The physician faculty must have current certification in the
236 subspecialty by the American Board of Internal Medicine or possess
237 qualifications acceptable to the Review Committee.
238
- 239 **II.B.4.** The physician faculty must possess current medical licensure and
240 appropriate medical staff appointment.
241
- 242 *II.B.5.* *The physician faculty must meet professional standards of ethical*
243 *behavior.*
244
- 245 **II.B.6.** The faculty must establish and maintain an environment of inquiry and
246 scholarship with an active research component.
247
- 248 **II.B.6.a)** The faculty must regularly participate in organized clinical
249 discussions, rounds, journal clubs, and conferences.
250
- 251 **II.B.6.b)** Some members of the faculty should also demonstrate
252 scholarship by one or more of the following:
253
- 254 **II.B.6.b).(1)** peer-reviewed funding;
255

256	II.B.6.b).(2)	publication of original research or review articles in peer-reviewed journals or chapters in textbooks;
257		
258		
259	II.B.6.b).(3)	publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,
260		
261		
262		
263	II.B.6.b).(4)	participation in national committees or educational organizations.
264		
265		
266	II.B.6.c)	Faculty should encourage and support fellows in scholarly activities.
267		
268		
269	II.B.7.	Key Clinical Faculty
270		
271		In addition to the program director, each program must have at least one Key Clinical Faculty (KCF). KCF are attending physicians who dedicate, on average, 10 hours per week throughout the year to the educational program. For programs with more than three fellows, <u>in the accredited portion of the educational program, there must be at least one KCF for every 1.5 fellows.</u>
272		
273		
274		
275		
276		
277		
278	II.B.7.a)	Key Clinical Faculty Qualifications
279		
280	II.B.7.a).(1)	KCF must be active clinicians with knowledge of, experience with, and commitment to transplant hepatology as a discipline.
281		
282		
283		
284	II.B.7.a).(2)	KCF must have current ABIM certification in transplant hepatology.
285		
286		
287	II.B.7.b)	<i>Key Clinical Faculty Responsibilities</i>
288		
289	II.B.7.b).(1)	<i>In addition to the responsibilities of all individual faculty members, the KCF with and the program director are responsible for the planning, implementation, monitoring and evaluation of the fellows' clinical and research <u>education-training.</u></i>
290		
291		
292		
293		
294		
295	II.B.7.b).(2)	<i>The majority <u>At least 50% of the KCF must demonstrate evidence of productivity in the scholarship, specifically, peer-reviewed funding; publication of original research, review articles, editorials, or case reports in peer-reviewed journals; or chapters in textbooks, as defined in II.B.5.b.(1), or (2) above</u></i>
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302	II.B.8.	<i>All Clinical faculty members should participate in prescribed faculty development programs designed to enhance the effectiveness of their teaching.</i>
303		
304		
305		
306	II.C.	Other Program Personnel

307
308 **The institution and the program must jointly ensure the availability of all**
309 **necessary professional, technical, and clerical personnel for the effective**
310 **administration of the program.**

311
312 *II.C.1. There must be services available from other health care professionals,*
313 *including dietitians, language interpreters, nurses, occupational*
314 *therapists, physical therapists, and social workers.*

315
316 *II.C.2. ~~There must be ensure the availability of~~ appropriate and timely*
317 *consultation from other specialties.*

318
319 *II.C.3. The program must incorporate a multidisciplinary team to approach*
320 *issues in donor selection and evaluation, and in recipient criteria.*

321
322 **II.D. Resources**

323
324 **The institution and the program must jointly ensure the availability of**
325 **adequate resources for fellow education, as defined in the specialty**
326 **program requirements.**

327
328 *II.D.1. Space and Equipment*

329
330 *There must be space and equipment for the ~~educational~~ program,*
331 *including such as meeting rooms, ~~classrooms~~, examination rooms,*
332 *computers, visual and other educational aids, and work/study space.*

333
334 *II.D.2. Facilities*

335
336 *II.D.2.a) Inpatient and outpatient systems must be in place to prevent*
337 *fellows from performing routine clerical functions, including*
338 *scheduling tests and appointments, and retrieving records and*
339 *letters.*

340
341 *II.D.2.b) The sponsoring institution must provide the broad range of*
342 *facilities and clinical support services required to provide*
343 *comprehensive care of adult patients. ~~Fellows must have clinical~~*
344 *experiences in efficient, effective ambulatory and inpatient care*
345 *settings.*

346
347 *II.D.2.c) Fellows must have access to a lounge facility during assigned*
348 *duty hours.*

349
350 *II.D.2.d) When fellows are ~~assigned night duty in the hospital,~~ assigned*
351 *night duty, or called in from home, they must be provided with ~~on-~~*
352 *call facilities that are convenient and that afford privacy, safety,*
353 *and a restful environment with a secure space for their*
354 *belongings.*

355
356 *II.D.2.e) ~~Each of~~ The following must be present at ~~t~~The primary training*
357 *clinical site must have interventional radiology facilities capable of*

- 358 performing balloon angioplasty and Transjugular Intrahepatic
 359 Portal Systemic Shunt.
 360
- 361 II.D.2.f) The primary clinical site must have a liver transplant program that
 362 is a member in good standing of the United Network for Organ
 363 Sharing (UNOS) or of the equivalent Canadian organization, and
 364 is affiliated with an ACGME-accredited gastroenterology training
 365 program.
 366
- 367 II.D.3. *Medical Records*
 368
 369 Access to an electronic health record should be provided. In the absence
 370 of an existing electronic health record, institutions must demonstrate
 371 institutional commitment to its development and progress toward its
 372 implementation.
 373
- 374 II.D.4. Patient Population
 375
- 376 II.D.4.a) The patient population must have a variety of clinical problems
 377 and stages of diseases.
 378
- 379 II.D.4.b) *There must be patients of ~~both~~ each gender, with a broad age*
 380 *range, including geriatric patients.*
 381
- 382 II.D.4.c) ~~For programs with one fellow, the transplant program must~~
 383 ~~perform at least 25 liver transplants per year.~~
 384
- 385 II.D.4.d) ~~For p~~ Programs with a complement of two or more fellows, ~~the~~
 386 ~~program~~ must perform 20 liver transplantations per year for each
 387 approved fellowship position.
 388
- 389 II.D.4.e) *A sufficient number of patients must be available to enable ensure*
 390 *adequate inpatient and ambulatory experience for each fellow to*
 391 *achieve the required educational outcomes.*
 392
- 393 **II.E. Medical Information Access**
 394
 395 **Fellows must have ready access to specialty-specific and other appropriate**
 396 **reference material in print or electronic format. Electronic medical literature**
 397 **databases with search capabilities should be available.**
 398
- 399 **III. Fellow Appointments**
 400
- 401 **III.A. Eligibility Criteria**
 402
 403 **Each fellow must successfully complete an ACGME-accredited specialty**
 404 **program and/or meet other eligibility criteria as specified by the Review**
 405 **Committee. The program must document that each fellow has met the**
 406 **eligibility criteria.**
 407
- 408 III.A.1. ~~Fellows~~ Prior to appointment in the fellowship, fellows entering should

409 | ~~have completed a three-year ACGME-accredited the program should~~
410 | ~~have completed a three-year ACGME-accredited gastroenterology~~
411 | ~~program fellowship.~~

412 |
413 | III.A.2. ~~Fellows from non-ACGME-accredited internal medicine education~~
414 | ~~programs must have completed at least three years of internal medicine~~
415 | ~~education prior to starting the fellowship.~~

416 |
417 | III.A.3. ~~The program director must inform non-ACGME-trained applicants from~~
418 | ~~non-ACGME-accredited programs, prior to appointment, and in writing, of~~
419 | ~~the ABIM policies and procedures that may will affect the fellow's their~~
420 | ~~eligibility for ABIM certification.~~

421 |
422 | III.A.4. ~~When averaged over any five-year period, a minimum of 75% of fellows in~~
423 | ~~each subspecialty training program must be graduates of an ACGME-~~
424 | ~~accredited internal medicine training program. Non-ACGME internal~~
425 | ~~medicine trained fellows must have at least three years of internal~~
426 | ~~medicine training prior to starting fellowship~~

427 |
428 | **III.B. Number of Fellows**

429 |
430 | **The program director may not appoint more fellows than approved by the**
431 | **Review Committee, unless otherwise stated in the specialty-specific**
432 | **requirements. The program's educational resources must be adequate to**
433 | **support the number of fellows appointed to the program.**

434 |
435 | III.B.1. ~~The minimum number of fellow positions in the training program~~
436 | ~~fellowship must not be less than the number of accredited training years~~
437 | ~~in the program~~

438 |
439 | **IV. Educational Program**

440 |
441 | **IV.A. The curriculum must contain the following educational components:**

442 |
443 | **IV.A.1. Skills and competencies the fellow will be able to demonstrate at the**
444 | **conclusion of the program. The program must distribute these skills**
445 | **and competencies to fellows and faculty annually, in either written**
446 | **or electronic form. These skills and competencies should be**
447 | **reviewed by the fellow at the start of each rotation;**

448 |
449 | **IV.A.2. ACGME Competencies**

450 |
451 | **The program must integrate the following ACGME competencies**
452 | **into the curriculum:**

453 |
454 | **IV.A.2.a) Patient Care**

455 |
456 | **Fellows must be able to provide patient care that is**
457 | **compassionate, appropriate, and effective for the treatment of**
458 | **health problems and the promotion of health. Fellows:**

459 |

460	IV.A.2.a).(1)	<i>must demonstrate competence in the practice of health promotion, disease prevention, diagnosis, care, and treatment of men and women patients of each gender, from adolescence to old age, during health and all stages of illness;</i>
461		
462		
463		
464		
465		
466	IV.A.2.a).(2)	Fellows must have formal instruction and clinical experience, and must demonstrate competence in: the following:
467		
468		
469		
470	IV.A.2.a).(2).(a)	the comprehensive management of patients high on the transplant list and in the intensive care setting with complications of end-stage liver disease, including refractory ascites, hepatic hydrothorax, hepatorenal syndrome, hepatopulmonary and portal pulmonary syndromes, and refractory portal hypertensive bleeding;
471		
472		
473		
474		
475		
476		
477		
478	IV.A.2.a).(2).(b)	the diagnosis and management of hepatocellular carcinoma and cholangiocarcinoma, including transplantation, <u>and</u> non-transplantation, <u>and</u> surgical, <u>and</u> non-surgical approaches;
479		
480		
481		
482		
483	IV.A.2.a).(2).(c)	Fellows must apply their knowledge of the ethical considerations relating to liver transplant donors, including questions related to living donors, non-heart beating donors, criteria for brain death, and appropriate <u>selection of</u> recipients in the care of transplant patients;
484		
485		
486		
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489		
490	IV.A.2.a).(2).(d)	the evaluation and management of both inpatients and outpatients with acute and chronic end-stage liver disease;
491		
492		
493		
494	IV.A.2.a).(2).(e)	the management of chronic viral hepatitis in the pre-transplantation, peri-transplantation, and post-transplantation settings;
495		
496		
497		
498	IV.A.2.a).(2).(f)	the management of fulminant liver failure;
499		
500	IV.A.2.a).(2).(g)	nutritional support of patients with chronic liver disease;
501		
502		
503	IV.A.2.a).(2).(h)	the performance of percutaneous liver biopsies, including allograft (each fellow must perform at least 30);
504		
505		
506		
507	IV.A.2.a).(2).(i)	the prevention of acute and chronic end-stage liver disease;
508		
509		
510	IV.A.2.a).(2).(j)	the psychosocial evaluation of all transplant

511		candidates, in particular those with a history of
512		substance abuse; and,
513		
514	IV.A.2.a).(2).(k)	the use of interventional radiology in the diagnosis
515		and management of portal hypertension, as well as
516		biliary and vascular complications.
517		
518	IV.A.2.b)	Medical Knowledge
519		
520		Fellows must demonstrate knowledge of established and
521		evolving biomedical, clinical, epidemiological and social-
522		behavioral sciences, as well as the application of this
523		knowledge to patient care. Fellows:
524		
525	IV.A.2.b).(1)	<i>must demonstrate knowledge of the scientific method of</i>
526		<i>problem solving and evidence-based decision making;</i>
527		<i>commitment to lifelong learning, and an attitude of caring</i>
528		<i>that is derived from humanistic and professional values.</i>
529		
530	IV.A.2.b).(2)	<i>must develop demonstrate a knowledge understanding of</i>
531		<i>indications, contraindications, limitations, complications,</i>
532		<i>techniques, and interpretation of results of those diagnostic</i>
533		<i>and therapeutic procedures integral to the discipline,</i>
534		<i><u>including the appropriate indication for and use of</u></i>
535		<i><u>screening tests/procedures;</u></i>
536		
537	IV.A.2.b).(3)	must demonstrate knowledge of:
538		
539	IV.A.2.b).(3).(a)	anatomy, physiology, pharmacology, pathology,
540		and molecular virology related to the liver and
541		biliary tract;
542		
543	IV.A.2.b).(3).(b)	drug hepatotoxicity and the interaction of drugs with
544		the liver;
545		
546	IV.A.2.b).(3).(c)	the impact of various modes of therapy and the
547		appropriate use of laboratory tests and procedures;
548		
549	IV.A.2.b).(3).(d)	the natural history of chronic liver disease;
550		
551	IV.A.2.b).(3).(e)	factors involved in nutrition and malnutrition and
552		their management;
553		
554	IV.A.2.b).(3).(f)	Fellows acquire a current working knowledge of the
555		organizational and logistic aspects of liver
556		transplantation, including the role of nurse
557		coordinators and other support staff (e.g., including
558		social work), organ procurement, and UNOS
559		policies, including those regarding organ allocation;
560		
561	IV.A.2.b).(3).(g)	principles and application of artificial liver support;

562		
563	IV.A.2.b).(3).(h)	Follows the principles of donor selection and rejection (e.g., hemodynamic management, donor organ steatosis, and indication for liver biopsy);
564		
565		
566		
567	IV.A.2.b).(3).(i)	principles of living donor selection, including appropriate surgical, psychosocial and ethical considerations;
568		
569		
570		
571	IV.A.2.b).(3).(j)	principles and practice of pediatric liver transplantation;
572		
573		
574	IV.A.2.b).(3).(k)	transplant immunology, including blood group matching, histocompatibility, tissue typing, and infectious and malignant complications of immunosuppression; and,
575		
576		
577		
578		
579	IV.A.2.b).(3).(l)	indications <u>for</u> , contraindications <u>for</u> , and complications of allograft biopsies.
580		
581		
582	IV.A.2.c)	Practice-based Learning and Improvement
583		
584		Fellows are expected to develop skills and habits to be able to meet the following goals:
585		
586		
587	IV.A.2.c).(1)	systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; and,
588		
589		
590		
591	IV.A.2.c).(2)	locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.
592		
593		
594		
595	IV.A.2.d)	Interpersonal and Communication Skills
596		
597		Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.
598		
599		
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601		
602	IV.A.2.e)	Professionalism
603		
604		Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.
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606		
607		
608	<i>IV.A.2.e).(1)</i>	<u><i>Fellows must demonstrate:</i></u>
609		
610	<i>IV.A.2.e).(1).(a)</i>	<u><i>high standards of ethical behavior, including maintaining appropriate professional boundaries and relationships with other physicians and other</i></u>
611		
612		

613 health care team members, and avoiding conflicts
614 of interest; and,

615
616 IV.A.2.e).(1).(b) a commitment to lifelong learning, and an attitude
617 of caring that is derived from humanistic and
618 professional values.

619
620 **IV.A.2.f) Systems-based Practice**

621
622 **Fellows must demonstrate an awareness of and**
623 **responsiveness to the larger context and system of health**
624 **care, as well as the ability to call effectively on other**
625 **resources in the system to provide optimal health care.**

626
627 IV.A.2.f).(1) Fellows must demonstrate prudent cost-effective and
628 judicious use of special instruments, tests, and therapies
629 in the diagnosis and management of liver disorders.

630
631 IV.A.3. Curriculum Organization and Fellow Experiences

632
633 IV.A.3.a) A subspecialty educational program in transplant hepatology must
634 function as an integral component of an ACGME-accredited
635 subspecialty fellowship in gastroenterology and be organized to
636 provide training and experience at a sufficient level for fellows to
637 acquire the competency of a specialist in the field. All 12 months
638 must include clinical experiences and appropriate protected (block
639 or concurrent) time for research.

640
641 IV.A.3.b) Fellows must participate in training using simulation.

642
643 IV.A.3.c) The core curriculum must include a didactic program based upon
644 the core knowledge content in the subspecialty area.

645
646 IV.A.3.c).(1) The program must afford each fellow an opportunity to
647 review topics covered in conferences that he or she was
648 unable to attend.

649
650 IV.A.3.c).(2) Fellows must participate in clinical case conferences,
651 journal clubs, research conference, and morbidity and
652 mortality or quality improvement conferences.

653
654 IV.A.3.c).(3) All core conferences must have at least one faculty
655 member present, and must be scheduled as to ensure
656 peer-peer and peer-faculty interaction.

657
658 IV.A.3.c).(4) Fellows must be instructed in practice management
659 relevant to transplant hepatology.

660
661 IV.A.3.d) Fellows Each fellow must participate in primary evaluation,
662 presentation, and discussion at selection conferences of at least
663 10 potential transplant candidates.

664		
665	IV.A.3.e)	Fellows <u>Each fellow</u> must provide follow-up for at least 20 new liver transplant recipients for a minimum of three months from the time of their transplantation.
666		
667		
668		
669	IV.A.3.f)	<u>Fellows must gain familiarity and expertise with the management of common long-term problems such as cardiovascular disease, acute and chronic kidney injury, screening for malignancies, and diagnosis and treatment of recurrent disease.</u>
670		
671		
672		
673		
674	IV.A.3.g)	Each fellow fellows must participate in the follow-up of 20 or more liver transplant recipients who have survived more than one year after transplantation. in order to gain familiarity and expertise with the management of common long-term problems (e.g., cardiovascular disease, acute and chronic kidney injury), screening for malignancies, and diagnosis and treatment of recurrent disease
675		
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681		
682	IV.A.3.g).(1)	There must be a minimum six-month follow-up period for each patient to ensure longitudinal care of transplant recipients.
683		
684		
685		
686	IV.A.3.h)	The <u>Each fellow</u> must actively participate in the transplant recipients' medical care, including management of acute cellular rejection, recurrent disease, infectious diseases, and biliary tract complications, and must serve as a primary member of the transplantation team and participate in making decisions about immunosuppression.
687		
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692		
693	IV.A.3.h).(1)	The fellows and faculty in the program must share patient co-management responsibilities with transplant surgeons from the pre-operative phase to the outpatient period.
694		
695		
696		
697	IV.A.3.h).(2)	The program must ensure close interactions and education with an experienced liver transplant pathologist.
698		
699		
700	IV.A.3.i)	Fellows must acquire a current working knowledge of the organizational and logistic aspects of liver transplantation including the role of nurse coordinators and other support staff (e.g., social work), organ procurement, and UNOS policies including those regarding organ allocation
701		
702		
703		
704		
705		
706	IV.A.3.j)	Fellows must learn the principles of donor selection and rejection (e.g., hemodynamic management, donor organ steatosis, and indication for liver biopsy
707		
708		
709		
710	IV.A.3.k)	Fellows must participate as an observer <u>observe</u> in one cadaveric liver procurement and three liver transplant surgeries.
711		
712		
713	IV.A.3.l)	Fellows must have formal instruction and clinical experience in interpretation of the following diagnostic and therapeutic
714		

- 715 techniques and procedures:
716
717 IV.A.3.l).(1) review of 200 native and allograft liver biopsies; and,
718
719 IV.A.3.l).(2) the appropriate use of ultrasound localized, laparoscopy-
720 guided and transjugular liver biopsies.
721
722 IV.A.3.m) Fellows must have formal didactic instruction in:
723
724 IV.A.3.m).(1) the pathogenesis, manifestations, and complications of
725 end-stage liver disease and hepatic transplantation,
726 including the behavioral adjustments of patients to their
727 problems.
728
729 ~~IV.A.3.m).(2) In addition to formal instruction in the areas outlined~~
730 ~~above, specific content areas that must be included in the~~
731 ~~formal education (lectures, conferences, seminars, and~~
732 ~~journal clubs) include the following:~~
733
734 ~~IV.A.3.m).(3) anatomy, physiology, pharmacology, pathology, and~~
735 ~~molecular virology related to the liver and biliary tract;~~
736
737 ~~IV.A.3.m).(4) the natural history of chronic liver disease;~~
738
739 ~~IV.A.3.m).(5) factors involved in nutrition and malnutrition and their~~
740 ~~management;~~
741
742 ~~IV.A.3.m).(6) principles and practice of pediatric liver transplantation;~~
743
744 ~~IV.A.3.m).(7) principles and application of artificial liver support; and~~
745
746 ~~IV.A.3.m).(8) principles of living donor selection, including appropriate~~
747 ~~surgical, psychosocial and ethical considerations.~~
748
749 IV.A.3.n) *Direct faculty supervision of procedures performed by each fellow*
750 *must occur until proficiency has been acquired and documented*
751 *by the program director.*
752
753 **IV.B. Fellows' Scholarly Activities**
754
755 IV.B.1. ~~Fellows should participate in scholarly activity. Each program must~~
756 ~~provide an opportunity for fellows to participate in research or other~~
757 ~~scholarly activities, including:~~
758
759 IV.B.1.a) a research project (with faculty mentorship); or
760
761 IV.B.1.b) participation with the faculty in the initiation and conduct of clinical
762 trials within the department; or,
763
764 IV.B.1.c) participation in quality assurance/quality improvement or process
765 improvement projects.

766		
767	IV.B.2.	<u>Up to 20 percent of their education may be occupied by fellows' scholarly activities, either concurrent with clinical experience, or in blocks.</u>
768		
769		
770	V. Evaluation	
771		
772	V.A. Fellow Evaluation	
773		
774	V.A.1. Formative Evaluation	
775		
776	V.A.1.a)	The faculty must evaluate fellow performance in a timely manner.
777		
778		
779	V.A.1.a).(1)	The faculty must discuss evaluations with each fellow at least every three months.
780		
781		
782	V.A.1.a).(2)	<u>Assessment of procedural competence should include a formal evaluation process and not be based solely on a minimum number of procedures performed.</u>
783		
784		
785		
786	V.A.1.b)	The program must:
787		
788	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;
789		
790		
791		
792		
793		
794	V.A.1.b).(1).(a)	<u>Patient Care</u>
795		
796		<u>The program must assess the 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>
797		
798		
799		
800		
801		
802	V.A.1.b).(1).(a).(i)	<u>Each program must define a standard criteria for proficiency competence for all required and elective procedures.</u>
803		
804		
805		
806	V.A.1.b).(1).(a).(ii)	<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>
807		
808		
809		
810		
811		
812	V.A.1.b).(1).(b)	<u>Medical Knowledge</u>
813		
814		<u>The program must use an objective formative assessment method. The same formative assessment method must be administered at least</u>
815		
816		

817		<u>twice during the program.</u>
818		
819	V.A. 1.b).(1).(c)	<u>Practice-based Learning and Improvement</u>
820		
821		<u>The program must use performance data to assess</u>
822		<u>the fellow in:</u>
823		
824	V.A. 1.b).(1).(c).(i)	<u>application of evidence to patient care;</u>
825		
826	V.A. 1.b).(1).(c).(ii)	<u>practice improvement;</u>
827		
828	V.A. 1.b).(1).(c).(iii)	<u>teaching skills involving peers and patients;</u>
829		<u>and,</u>
830		
831	V.A. 1.b).(1).(c).(iv)	<u>scholarship.</u>
832		
833	V.A. 1.b).(1).(d)	<u>Interpersonal and Communication Skills</u>
834		
835		<u>The program must use both direct observation and</u>
836		<u>multi-source evaluation, including patients, peers</u>
837		<u>and non-physician team members, to assess fellow</u>
838		<u>performance in:</u>
839		
840	V.A. 1.b).(1).(d).(i)	<u>communication with patient and family;</u>
841		
842	V.A. 1.b).(1).(d).(ii)	<u>teamwork;</u>
843		
844	V.A. 1.b).(1).(d).(iii)	<u>communication with peers, including</u>
845		<u>transitions in care; and,</u>
846		
847	V.A. 1.b).(1).(d).(iv)	<u>record keeping.</u>
848		
849	V.A. 1.b).(1).(e)	<u>Professionalism</u>
850		
851		<u>The program must use multi-source evaluation,</u>
852		<u>including patients, peers, and non-physician team</u>
853		<u>members, to assess each fellow's:</u>
854		
855	V.A. 1.b).(1).(e).(i)	<u>honesty and integrity;</u>
856		
857	V.A. 1.b).(1).(e).(ii)	<u>ability to meet professional responsibilities;</u>
858		
859	V.A. 1.b).(1).(e).(iii)	<u>ability to maintain appropriate professional</u>
860		<u>relationships with patients and colleagues;</u>
861		<u>and,</u>
862		
863	V.A. 1.b).(1).(e).(iv)	<u>commitment to self-improvement.</u>
864		
865	V.A. 1.b).(1).(f)	<u>Systems-based Practice</u>
866		
867		<u>The program must use multi-source evaluation.</u>

868		<u>including peers, and non-physician team members,</u>
869		<u>to assess each fellow's:</u>
870		
871	V.A. 1.b).(1).(f).(i)	<u>ability to provide care coordination,</u>
872		<u>including transition of care;</u>
873		
874	V.A. 1.b).(1).(f).(ii)	<u>ability to work in interdisciplinary teams;</u>
875		
876	V.A. 1.b).(1).(f).(iii)	<u>advocacy for quality of care; and,</u>
877		
878	V.A. 1.b).(1).(f).(iv)	<u>ability to identify system problems and</u>
879		<u>participate in improvement activities.</u>
880		
881	V.A.1.b).(2)	use multiple evaluators (e.g., faculty, peers, patients,
882		self, and other professional staff); and,
883		
884	V.A.1.b).(3)	provide each fellow with documented semiannual
885		evaluation of performance with feedback.
886		
887	V.A.1.c)	The evaluations of fellow performance must be accessible for
888		review by the fellow, in accordance with institutional policy.
889		
890	V.A.2.	Summative Evaluation
891		
892		The program director must provide a summative evaluation for each
893		fellow upon completion of the program. This evaluation must
894		become part of the fellow's permanent record maintained by the
895		institution, and must be accessible for review by the fellow in
896		accordance with institutional policy. This evaluation must:
897		
898	V.A.2.a)	document the fellow's performance during their education;
899		and,
900		
901	V.A.2.b)	verify that the fellow has demonstrated sufficient competence
902		to enter practice without direct supervision.
903		
904	V.B.	Faculty Evaluation
905		
906	V.B.1.	At least annually, the program must evaluate faculty performance as
907		it relates to the educational program.
908		
909	V.B.2.	These evaluations should include a review of the faculty's clinical
910		teaching abilities, commitment to the educational program, clinical
911		knowledge, professionalism, and scholarly activities.
912		
913	V.B.3.	In addition, <i>Fellows must have the opportunity to provide confidential</i>
914		<i>written evaluations of each supervising faculty <u>member</u> at the end of a</i>
915		<i><u>each</u> rotation.</i>
916		
917	V.B.4.	be reviewed <i>These evaluations must be reviewed with <u>attending each</u></i>
918		<i><u>faculty member</u> annually.</i>

- 919
- 920 **V.C. Program Evaluation and Improvement**
- 921
- 922 **V.C.1. The program must document formal, systematic evaluation of the**
- 923 **curriculum at least annually. The program must monitor and track**
- 924 **each of the following areas:**
- 925
- 926 **V.C.1.a) fellow performance;**
- 927
- 928 **V.C.1.b) faculty development; and,**
- 929
- 930 **V.C.1.c) graduate performance, including performance of program**
- 931 **graduates on the certification examination.**
- 932
- 933 **V.C.1.c).(1)** *At least 80% of program's graduating fellows from those*
- 934 *eligible to take an ABIM subspecialty certifying*
- 935 *examination upon completion of their training for the most*
- 936 *recently defined five-year period who are eligible should*
- 937 *must have taken an the ABIM subspecialty certifying*
- 938 *examination. (Note: Five-year rolling pass rate for first time*
- 939 *takers of the ABIM certifying examination will be examined*
- 940 *at each program review).*
- 941
- 942 **V.C.1.c).(1)** *At least 80% of a program's graduates taking the ABIM*
- 943 *certifying examination for the first time during the most*
- 944 *recently defined five year period should pass.*
- 945
- 946 **V.C.1.c).(2)** *At least 80% of the entering fellows should have*
- 947 *completed the program when averaged over a five-year*
- 948 *period.*
- 949
- 950 **V.C.2. If deficiencies are found, the program should prepare a written plan**
- 951 **of action to document initiatives to improve performance in the**
- 952 **areas listed in section V.C.1. The action plan should be reviewed**
- 953 **and approved by the teaching faculty and documented in meeting**
- 954 **minutes.**
- 955
- 956 **V.C.2.a)** *Representative program personnel, at a minimum to include the*
- 957 *program director, representative faculty, and one fellow, must*
- 958 *review program goals and objectives, and the effectiveness with*
- 959 *which they are achieved.*
- 960
- 961 **VI. Fellow Duty Hours in the Learning and Working Environment**
- 962
- 963 **VI.A. Professionalism, Personal Responsibility, and Patient Safety**
- 964
- 965 **VI.A.1. Programs and sponsoring institutions must educate fellows and**
- 966 **faculty members concerning the professional responsibilities of**
- 967 **physicians to appear for duty appropriately rested and fit to provide**
- 968 **the services required by their patients.**
- 969

- 970 VI.A.2. The program must be committed to and responsible for promoting
 971 patient safety and fellow well-being in a supportive educational
 972 environment.
 973
- 974 VI.A.3. The program director must ensure that fellows are integrated and
 975 actively participate in interdisciplinary clinical quality improvement
 976 and patient safety programs.
 977
- 978 VI.A.4. The learning objectives of the program must:
 979
- 980 VI.A.4.a) be accomplished through an appropriate blend of supervised
 981 patient care responsibilities, clinical teaching, and didactic
 982 educational events; and,
 983
- 984 VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill
 985 non-physician service obligations.
 986
- 987 ~~VI.A.1.a).(1) ————— *Fellows' service responsibilities must be limited to patients*~~
 988 ~~*for whom the teaching service has diagnostic and*~~
 989 ~~*therapeutic responsibility.*~~
 990
- 991 VI.A.5. The program director and sponsoring institution must ensure a
 992 culture of professionalism that supports patient safety and personal
 993 responsibility. Fellows and faculty members must demonstrate an
 994 understanding and acceptance of their personal role in the
 995 following:
 996
- 997 VI.A.5.a) assurance of the safety and welfare of patients entrusted to
 998 their care;
 999
- 1000 VI.A.5.b) provision of patient- and family-centered care;
 1001
- 1002 VI.A.5.c) assurance of their fitness for duty;
 1003
- 1004 VI.A.5.d) management of their time before, during, and after clinical
 1005 assignments;
 1006
- 1007 VI.A.5.e) recognition of impairment, including illness and fatigue, in
 1008 themselves and in their peers;
 1009
- 1010 VI.A.5.f) attention to lifelong learning;
 1011
- 1012 VI.A.5.g) the monitoring of their patient care performance improvement
 1013 indicators; and,
 1014
- 1015 VI.A.5.h) honest and accurate reporting of duty hours, patient
 1016 outcomes, and clinical experience data.
 1017
- 1018 VI.A.6. All fellows and faculty members must demonstrate responsiveness
 1019 to patient needs that supersedes self-interest. Physicians must
 1020 recognize that under certain circumstances, the best interests of the

1021		patient may be served by transitioning that patient's care to another
1022		qualified and rested provider.
1023		
1024	VI.B.	Transitions of Care
1025		
1026	VI.B.1.	Programs must design clinical assignments to minimize the number
1027		of transitions in patient care.
1028		
1029	VI.B.2.	Sponsoring institutions and programs must ensure and monitor
1030		effective, structured hand-over processes to facilitate both
1031		continuity of care and patient safety.
1032		
1033	VI.B.3.	Programs must ensure that fellows are competent in communicating
1034		with team members in the hand-over process.
1035		
1036	VI.B.4.	The sponsoring institution must ensure the availability of schedules
1037		that inform all members of the health care team of attending
1038		physicians and fellows currently responsible for each patient's care.
1039		
1040	VI.C.	Alertness Management/Fatigue Mitigation
1041		
1042	VI.C.1.	The program must:
1043		
1044	VI.C.1.a)	educate all faculty members and fellows to recognize the
1045		signs of fatigue and sleep deprivation;
1046		
1047	VI.C.1.b)	educate all faculty members and fellows in alertness
1048		management and fatigue mitigation processes; and,
1049		
1050	VI.C.1.c)	adopt fatigue mitigation processes to manage the potential
1051		negative effects of fatigue on patient care and learning, such
1052		as naps or back-up call schedules.
1053		
1054	VI.C.2.	Each program must have a process to ensure continuity of patient
1055		care in the event that a fellow may be unable to perform his/her
1056		patient care duties.
1057		
1058	VI.C.3.	The sponsoring institution must provide adequate sleep facilities
1059		and/or safe transportation options for fellows who may be too
1060		fatigued to safely return home.
1061		
1062	VI.D.	Supervision of Fellows
1063		
1064	VI.D.1.	In the clinical learning environment, each patient must have an
1065		identifiable, appropriately-credentialed and privileged attending
1066		physician (or licensed independent practitioner as approved by each
1067		Review Committee) who is ultimately responsible for that patient's
1068		care.
1069		
1070	VI.D.1.a)	This information should be available to fellows, faculty
1071		members, and patients.

1072		
1073	VI.D.1.b)	Fellows and faculty members should inform patients of their
1074		respective roles in each patient’s care.
1075		
1076	VI.D.2.	The program must demonstrate that the appropriate level of
1077		supervision is in place for all fellows who care for patients.
1078		
1079		Supervision may be exercised through a variety of methods. Some
1080		activities require the physical presence of the supervising faculty
1081		member. For many aspects of patient care, the supervising
1082		physician may be a more advanced fellow. Other portions of care
1083		provided by the fellow can be adequately supervised by the
1084		immediate availability of the supervising faculty member or fellow
1085		physician, either in the institution, or by means of telephonic and/or
1086		electronic modalities. In some circumstances, supervision may
1087		include post-hoc review of fellow-delivered care with feedback as to
1088		the appropriateness of that care.
1089		
1090	VI.D.3.	Levels of Supervision
1091		
1092		To ensure oversight of fellow supervision and graded authority and
1093		responsibility, the program must use the following classification of
1094		supervision:
1095		
1096	VI.D.3.a)	Direct Supervision – the supervising physician is physically
1097		present with the fellow and patient.
1098		
1099	VI.D.3.b)	Indirect Supervision:
1100		
1101	VI.D.3.b).(1)	with direct supervision immediately available – the
1102		supervising physician is physically within the hospital
1103		or other site of patient care, and is immediately
1104		available to provide Direct Supervision.
1105		
1106	VI.D.3.b).(2)	with direct supervision available – the supervising
1107		physician is not physically present within the hospital
1108		or other site of patient care, but is immediately
1109		available by means of telephonic and/or electronic
1110		modalities, and is available to provide Direct
1111		Supervision.
1112		
1113	VI.D.3.c)	Oversight – the supervising physician is available to provide
1114		review of procedures/encounters with feedback provided
1115		after care is delivered.
1116		
1117	VI.D.4.	The privilege of progressive authority and responsibility, conditional
1118		independence, and a supervisory role in patient care delegated to
1119		each fellow must be assigned by the program director and faculty
1120		members.
1121		
1122	VI.D.4.a)	The program director must evaluate each fellow’s abilities

1123 based on specific criteria. When available, evaluation should
1124 be guided by specific national standards-based criteria.
1125

1126 **VI.D.4.b)** Faculty members functioning as supervising physicians
1127 should delegate portions of care to fellows, based on the
1128 needs of the patient and the skills of the fellows.
1129

1130 **VI.D.4.c)** Fellows should serve in a supervisory role of residents or
1131 junior fellows in recognition of their progress toward
1132 independence, based on the needs of each patient and the
1133 skills of the individual fellow.
1134

1135 **VI.D.5.** Programs must set guidelines for circumstances and events in
1136 which fellows must communicate with appropriate supervising
1137 faculty members, such as the transfer of a patient to an intensive
1138 care unit, or end-of-life decisions.
1139

1140 **VI.D.5.a)** Each fellow must know the limits of his/her scope of
1141 authority, and the circumstances under which he/she is
1142 permitted to act with conditional independence.
1143

1144 **VI.D.6.** Faculty supervision assignments should be of sufficient duration to
1145 assess the knowledge and skills of each fellow and delegate to
1146 him/her the appropriate level of patient care authority and
1147 responsibility.
1148

1149 **VI.E.** **Clinical Responsibilities**

1150
1151 The clinical responsibilities for each fellow must be based on PGY-level,
1152 patient safety, fellow education, severity and complexity of patient
1153 illness/condition and available support services.
1154

1155 **VI.F.** **Teamwork**

1156
1157 Fellows must care for patients in an environment that maximizes effective
1158 communication. This must include the opportunity to work as a member of
1159 effective interprofessional teams that are appropriate to the delivery of care
1160 in the specialty.
1161

1162 **VI.G.** **Fellow Duty Hours**

1163

1164 **VI.G.1.** **Maximum Hours of Work per Week**

1165
1166 Duty hours must be limited to 80 hours per week, averaged over a
1167 four-week period, inclusive of all in-house call activities and all
1168 moonlighting.
1169

1170 **VI.G.1.a)** **Duty Hour Exceptions**

1171
1172 A Review Committee may grant exceptions for up to 10% or a
1173 maximum of 88 hours to individual programs based on a

1174		sound educational rationale.
1175		
1176		<i>The Review Committee for Internal Medicine will not consider</i>
1177		<i>requests for exceptions to the 80-hour limit to the fellows' work</i>
1178		<i>week.</i>
1179		
1180	VI.G.1.a).(1)	In preparing a request for an exception the program
1181		director must follow the duty hour exception policy
1182		from the ACGME Manual on Policies and Procedures.
1183		
1184	VI.G.1.a).(2)	Prior to submitting the request to the Review
1185		Committee, the program director must obtain approval
1186		of the institution's GMEC and DIO.
1187		
1188	VI.G.2.	Moonlighting
1189		
1190	VI.G.2.a)	Moonlighting must not interfere with the ability of the fellow
1191		to achieve the goals and objectives of the educational
1192		program.
1193		
1194	VI.G.2.b)	Time spent by fellows in Internal and External Moonlighting
1195		(as defined in the ACGME Glossary of Terms) must be
1196		counted towards the 80-hour Maximum Weekly Hour Limit.
1197		
1198	VI.G.3.	Mandatory Time Free of Duty
1199		
1200		Fellows must be scheduled for a minimum of one day free of duty
1201		every week (when averaged over four weeks). At-home call cannot
1202		be assigned on these free days.
1203		
1204	VI.G.4.	Maximum Duty Period Length
1205		
1206		Duty periods of fellows may be scheduled to a maximum of 24 hours
1207		of continuous duty in the hospital. Programs must encourage
1208		fellows to use alertness management strategies in the context of
1209		patient care responsibilities. Strategic napping, especially after 16
1210		hours of continuous duty and between the hours of 10:00 p.m. and
1211		8:00 a.m., is strongly suggested.
1212		
1213	VI.G.4.a)	It is essential for patient safety and fellow education that
1214		effective transitions in care occur. Fellows may be allowed to
1215		remain on-site in order to accomplish these tasks; however,
1216		this period of time must be no longer than an additional four
1217		hours.
1218		
1219	VI.G.4.b)	Fellows must not be assigned additional clinical
1220		responsibilities after 24 hours of continuous in-house duty.
1221		
1222	VI.G.4.c)	In unusual circumstances, fellows, on their own initiative,
1223		may remain beyond their scheduled period of duty to
1224		continue to provide care to a single patient. Justifications for

1225		such extensions of duty are limited to reasons of required
1226		continuity for a severely ill or unstable patient, academic
1227		importance of the events transpiring, or humanistic attention
1228		to the needs of a patient or family.
1229		
1230	VI.G.4.c).(1)	Under those circumstances, the fellow must:
1231		
1232	VI.G.4.c).(1).(a)	appropriately hand over the care of all other
1233		patients to the team responsible for their
1234		continuing care; and,
1235		
1236	VI.G.4.c).(1).(b)	document the reasons for remaining to care for
1237		the patient in question and submit that
1238		documentation in every circumstance to the
1239		program director.
1240		
1241	VI.G.4.c).(2)	The program director must review each submission of
1242		additional service, and track both individual fellow and
1243		program-wide episodes of additional duty.
1244		
1245	VI.G.5.	Minimum Time Off between Scheduled Duty Periods
1246		
1247	VI.G.5.a)	Fellows must be prepared to enter the unsupervised practice
1248		of medicine and care for patients over irregular or extended
1249		periods.
1250		
1251		<u>Internal medicine subspecialty fellows are considered to be in the</u>
1252		<u>final years of education.</u>
1253		
1254	VI.G.5.a).(1)	This preparation must occur within the context of the
1255		80-hour, maximum duty period length, and one-day-
1256		off-in-seven standards. While it is desirable that
1257		fellows have eight hours free of duty between
1258		scheduled duty periods, there may be circumstances
1259		when these fellows must stay on duty to care for their
1260		patients or return to the hospital with fewer than eight
1261		hours free of duty.
1262		
1263	VI.G.5.a).(1).(a)	Circumstances of return-to-hospital activities
1264		with fewer than eight hours away from the
1265		hospital by fellows must be monitored by the
1266		program director.
1267		
1268	VI.G.5.a).(1).(b)	<u>In unusual circumstances, fellows may remain</u>
1269		<u>beyond their scheduled period of duty or return</u>
1270		<u>after their scheduled period of duty to provide care</u>
1271		<u>to a single patient. Justifications for such</u>
1272		<u>extensions of duty are limited to reasons of</u>
1273		<u>required continuity of care for a severely ill or</u>
1274		<u>unstable patient, academic importance of the</u>
1275		<u>events transpiring, or humanistic attention to the</u>

1276 needs of the patient or family. Such episodes
1277 should be rare, must be of the fellows' own
1278 initiative, and need not initiate a new 'off-duty
1279 period' nor require a change in the scheduled 'off-
1280 duty period.'

1281
1282 VI.G.5.a).(1).(c) Under such circumstances, the fellow must
1283 appropriately hand over care of all other patients to
1284 the team responsible for their continuing care, and
1285 document the reasons for remaining or returning to
1286 care for the patient in question and submit that
1287 documentation to the program director.

1288
1289 VI.G.5.a).(1).(d) The program director must review each submission
1290 of additional service and track both individual
1291 fellows' and program-wide episodes of additional
1292 duty.

1293
1294 **VI.G.6. Maximum Frequency of In-House Night Float**

1295
1296 **Fellows must not be scheduled for more than six consecutive nights**
1297 **of night float.**

1298
1299 **VI.G.7. Maximum In-House On-Call Frequency**

1300
1301 **Fellows must be scheduled for in-house call no more frequently than**
1302 **every-third-night (when averaged over a four-week period).**

1303
1304 VI.G.7.a) *Internal Medicine ~~residency programs are~~ fellowships must not*
1305 *allowed to average in-house call over a four-week period.*

1306
1307 **VI.G.8. At-Home Call**

1308
1309 **VI.G.8.a) Time spent in the hospital by fellows on at-home call must**
1310 **count towards the 80-hour maximum weekly hour limit. The**
1311 **frequency of at-home call is not subject to the every-third-**
1312 **night limitation, but must satisfy the requirement for one-day-**
1313 **in-seven free of duty, when averaged over four weeks.**

1314
1315 **VI.G.8.a).(1) At-home call must not be so frequent or taxing as to**
1316 **preclude rest or reasonable personal time for each**
1317 **fellow.**

1318
1319 **VI.G.8.b) Fellows are permitted to return to the hospital while on at-**
1320 **home call to care for new or established patients. Each**
1321 **episode of this type of care, while it must be included in the**
1322 **80-hour weekly maximum, will not initiate a new "off-duty**
1323 **period".**

1324
1325 ACGME Approved: February 5, 2011 Effective: July 1, 2012