

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Advanced Heart Failure and Transplant Cardiology (Internal Medicine)**
3

4 **Common Program Requirements are in BOLD**
5 *General Subspecialty Requirements are ITALICIZED*
6

7 Effective:
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. Advanced heart failure and transplant cardiology encompasses the unique**
37 **knowledge and skills required to care for patients with advanced heart failure,**
38 **and those who have undergone or are awaiting transplantation.**
39

40 **Int.C. The educational program in advanced heart failure and transplant cardiology**
41 **must be 12 months 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 the 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. An advanced heart failure and transplant cardiology fellowship must
56 function as an integral part of an ACGME-accredited fellowship in
57 cardiovascular disease.

58
59 I.A.2. *The sponsoring institution must provide the program director with*
60 *adequate support for the administrative activities of the program.*

61
62 I.A.2.a) *The program director must not be required to generate clinical or*
63 *other income to provide this administrative support.*

64
65 I.A.2.b) *It is suggested that this support should be 25-50% of the program*
66 *director's salary, or protected time, depending on the size of the*
67 *program.*

68
69 I.A.3. *The sponsoring institution and participating sites must:*

70
71 I.A.3.a) *demonstrate that there is a culture of continuous quality*
72 *improvement in the areas of patient care, patient safety, and*
73 *education;*

74
75 I.A.3.b) *demonstrate a commitment to quality patient-centered care and*
76 *safety, education, and scholarship sufficient to support the*
77 *fellowship; and,*

78
79 I.A.3.c) *share appropriate inpatient and outpatient faculty performance*
80 *data with the program director.*

81
82 **I.B. Participating Sites**

83
84 **I.B.1. There must be a program letter of agreement (PLA) between the**
85 **program and each participating site providing a required**
86 **assignment. The PLA must be renewed at least every five years.**

87
88 **The PLA should:**

89
90 **I.B.1.a) identify the faculty who will assume both educational and**
91 **supervisory responsibilities for fellows;**

92
93 **I.B.1.b) specify their responsibilities for teaching, supervision, and**
94 **formal evaluation of fellows, as specified later in this**
95 **document;**

96
97 **I.B.1.c) specify the duration and content of the educational**
98 **experience; and,**

99
100 **I.B.1.d) state the policies and procedures that will govern fellow**
101 **education during the assignment.**

102

- 103 **I.B.2.** **The program director must submit any additions or deletions of**
104 **participating sites routinely providing an educational experience,**
105 **required for all fellows, of one month full time equivalent (FTE) or**
106 **more through the Accreditation Council for Graduate Medical**
107 **Education (ACGME) Accreditation Data System (ADS).**
108
- 109 **II. Program Personnel and Resources**
110
- 111 **II.A. Program Director**
112
- 113 **II.A.1.** **There must be a single program director with authority and**
114 **accountability for the operation of the program. The sponsoring**
115 **institution’s GMEC must approve a change in program director.**
116 **After approval, the program director must submit this change to the**
117 **ACGME via the ADS.**
118
- 119 **II.A.2.** **Qualifications of the program director must include:**
120
- 121 **II.A.2.a)** **requisite specialty expertise and documented educational**
122 **and administrative experience acceptable to the Review**
123 **Committee;**
124
- 125 II.A.2.a).(1) The program director must have at least five years of
126 participation as an active faculty member in an ACGME-
127 accredited internal medicine cardiovascular disease
128 fellowship or advanced heart failure and transplant
129 cardiology fellowship.
130
- 131 **II.A.2.b)** **current certification in the subspecialty by the American**
132 **Board of Internal Medicine (ABIM), or subspecialty**
133 **qualifications that are acceptable to the Review Committee;**
134 **and**
135
- 136 II.A.2.b).(1) The Review Committee only accepts current ABIM
137 certification in advanced heart failure and transplant
138 cardiology.
139
- 140 **II.A.2.c)** **current medical licensure and appropriate medical staff**
141 **appointment.**
142
- 143 **II.A.3.** **The program director must administer and maintain an educational**
144 **environment conducive to educating the fellows in each of the**
145 **ACGME competency areas. The program director must:**
146
- 147 **II.A.3.a)** **prepare and submit all information required and requested by**
148 **the ACGME;**
149
- 150 **II.A.3.b)** **be familiar with and oversee compliance with ACGME and**
151 **Review Committee policies and procedures as outlined in the**
152 **ACGME Manual of Policies and Procedures;**
153

- 154 **II.A.3.c)** **obtain review and approval of the sponsoring institution's**
 155 **GMEC/DIO before submitting to the ACGME information or**
 156 **requests for the following:**
 157
- 158 **II.A.3.c).(1)** **all applications for ACGME accreditation of new**
 159 **programs;**
 160
- 161 **II.A.3.c).(2)** **changes in fellow complement;**
 162
- 163 **II.A.3.c).(3)** **major changes in program structure or length of**
 164 **training;**
 165
- 166 **II.A.3.c).(4)** **progress reports requested by the Review Committee;**
 167
- 168 **II.A.3.c).(5)** **responses to all proposed adverse actions;**
 169
- 170 **II.A.3.c).(6)** **requests for increases or any change to fellow duty**
 171 **hours;**
 172
- 173 **II.A.3.c).(7)** **voluntary withdrawals of ACGME-accredited**
 174 **programs;**
 175
- 176 **II.A.3.c).(8)** **requests for appeal of an adverse action; and**
 177
- 178 **II.A.3.c).(9)** **appeal presentations to a Board of Appeal or the**
 179 **ACGME.**
 180
- 181 **II.A.3.d)** **obtain DIO review and co-signature on all program**
 182 **information forms, as well as any correspondence or**
 183 **document submitted to the ACGME that addresses:**
 184
- 185 **II.A.3.d).(1)** **program citations; and/or**
 186
- 187 **II.A.3.d).(2)** **requests for changes in the program that would have**
 188 **significant impact, including financial, on the program**
 189 **or institution.**
 190
- 191 **II.A.3.e)** *ensure that fellows' service responsibilities are limited to patients*
 192 *for whom the teaching service has diagnostic and therapeutic*
 193 *responsibility;*
 194
- 195 **II.A.3.f)** *dedicate an average of 20 hours per week of his or her*
 196 *professional effort to the program, including time for administration*
 197 *of the program;*
 198
- 199 **II.A.3.g)** *have a reporting relationship with the program director of the*
 200 *cardiovascular disease program to ensure compliance with*
 201 *ACGME accreditation standards; and,*
 202
- 203 **II.A.3.h)** *be available at the primary clinical site.*
 204

- 205 **II.B. Faculty**
206
- 207 **II.B.1. There must be a sufficient number of faculty with documented**
208 **qualifications to instruct and supervise all fellows.**
209
- 210 **II.B.2. The faculty must devote sufficient time to the educational program**
211 **to fulfill their supervisory and teaching responsibilities and**
212 **demonstrate a strong interest in the education of fellows.**
213
- 214 **II.B.3. The physician faculty must have current certification in the**
215 **subspecialty by the American Board of Internal Medicine or possess**
216 **qualifications acceptable to the Review Committee.**
217
- 218 **II.B.4. The physician faculty must possess current medical licensure and**
219 **appropriate medical staff appointment.**
220
- 221 **II.B.5. *The physician faculty must meet professional standards of ethical***
222 ***behavior.***
223
- 224 **II.B.6. *The faculty must establish and maintain an environment of inquiry and***
225 ***scholarship with an active research component.***
226
- 227 **II.B.6.a) *The faculty must regularly participate in organized clinical***
228 ***discussions, rounds, journal clubs, and conferences.***
229
- 230 **II.B.6.b) *Some members of the faculty should also demonstrate***
231 ***scholarship by one or more of the following:***
232
- 233 **II.B.6.b).(1) *peer-reviewed funding;***
234
- 235 **II.B.6.b).(2) *publication of original research or review articles in peer-***
236 ***reviewed journals or chapters in textbooks;***
237
- 238 **II.B.6.b).(3) *publication or presentation of case reports or clinical series***
239 ***at local, regional, or national professional and scientific***
240 ***society meetings; or,***
241
- 242 **II.B.6.b).(4) *participation in national committees or educational***
243 ***organizations.***
244
- 245 **II.B.6.c) *Faculty should encourage and support fellows in scholarly***
246 ***activities.***
247
- 248 **II.B.7. Key Clinical Faculty**
249
- 250 In addition to the program director, each program must have at least one
251 Key Clinical Faculty (KCF). KCF are attending physicians who dedicate,
252 on average, 10 hours per week throughout the year to the program. For
253 programs with more than two fellows, there must be at least one KCF for
254 every 1.5 fellows.
255

256	II.B.7.a)	Key Clinical Faculty Qualifications:
257		
258	II.B.7.a).(1)	KCF must be active clinicians with knowledge of,
259		experience with, and commitment to advanced heart failure
260		and transplant cardiology as a discipline.
261		
262	II.B.8.a).(2)	KCF must have current ABIM certification in advanced
263		heart failure and transplant cardiology.
264		
265	II.B.7.b)	<i>Key Clinical Faculty Responsibilities</i>
266		
267	II.B.7.b).(1)	<i>In addition to the responsibilities of all individual faculty</i>
268		<i>members, the KCF and the program director are</i>
269		<i>responsible for the planning, implementation, monitoring</i>
270		<i>and evaluation of the fellows' clinical and research</i>
271		<i>education.</i>
272		
273	II.B.7.b).(2)	<i>At least 50% of the KCF must demonstrate evidence of</i>
274		<i>productivity in scholarship, specifically, peer-reviewed</i>
275		<i>funding; publication of original research, review articles,</i>
276		<i>editorials, or case reports in peer-reviewed journals; or</i>
277		<i>chapters in textbooks.</i>
278		
279	II.B.8.	<i>Clinical faculty members should participate in faculty development</i>
280		<i>programs designed to enhance the effectiveness of their teaching.</i>
281		
282	II.C.	Other Program Personnel
283		
284		The institution and the program must jointly ensure the availability of all
285		necessary professional, technical, and clerical personnel for the effective
286		administration of the program.
287		
288	II.C.1.	<i>There must be services available from other health care professionals,</i>
289		<i>including dietitians, language interpreters, nurses, occupational therapists</i>
290		<i>physical therapists, and social workers.</i>
291		
292	II.C.2.	The program must incorporate a multidisciplinary team approach in the
293		management of patients.
294		
295	II.C.3.	<i>There must be appropriate and timely consultation from other specialties.</i>
296		
297	II.D.	Resources
298		
299		The institution and the program must jointly ensure the availability of
300		adequate resources for fellow education, as defined in the specialty
301		program requirements.
302		
303	II.D.1.	<i>Space and Equipment</i>
304		
305		<i>There must be space and equipment for the program, including meeting</i>
306		<i>rooms, examination rooms, computers, visual and other educational aids,</i>

307 *and work/study space.*

308

309 II.D.2.

Facilities

310

311 II.D.2.a)

Inpatient and outpatient systems must be in place to prevent fellows from performing routine clerical functions, including scheduling tests and appointments, and retrieving records and letters.

312

313

314

315

316 II.D.2.b)

The sponsoring institution must provide the broad range of facilities and clinical support services required to provide comprehensive care of adult patients.

317

318

319

320 II.D.2.c)

Fellows must have access to a lounge facility during assigned duty hours.

321

322

323 II.D.2.d)

When fellows are in the hospital, assigned night duty, or called in from home, they must be provided with a secure space for their belongings.

324

325

326

327 II.D.3.

Medical Records

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329

330

331

332

Access to an electronic health record should be provided. In the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development and progress toward its implementation.

333

334

Patient Population

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336 II.D.3.a)

The patient population must have a variety of clinical problems and stages of diseases, and must include a full range of patients with advanced or complex heart failure.

337

338

339

340 II.D.3.b)

There must be patients of each gender, with a broad age range, including geriatric patients.

341

342

343 II.D.3.c)

A sufficient number of patients must be available to enable each fellow to achieve the required educational outcomes. This must include:

344

345

346

347 II.D.3.c).(1)

200 hospitalized patients diagnosed with heart failure, including both pre- and post-transplant patients and patients with ventricular assist devices; and,

348

349

350

351 II.D.3.c).(2)

ambulatory patients, including a wide variety of patients with heart failure, transplants, and mechanical circulatory support.

352

353

354

355 **II.E.**

Medical Information Access

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

357

358 reference material in print or electronic format. Electronic medical literature
359 databases with search capabilities should be available.

360
361 **III. Fellow Appointments**

362
363 **III.A. Eligibility Criteria**

364
365 **Each fellow must successfully complete an ACGME-accredited specialty**
366 **program and/or meet other eligibility criteria as specified by the Review**
367 **Committee. The program must document that each fellow has met the**
368 **eligibility criteria.**

369
370 III.A.1. Prior to appointment in the fellowship, fellows should have completed a
371 three-year ACGME-accredited cardiovascular disease program.

372
373 III.A.2. Fellows from non-ACGME-accredited programs must have at least three
374 years of cardiovascular disease education prior to starting the fellowship.

375
376 III.A.3. *The program director must inform applicants from non-ACGME-*
377 *accredited programs, prior to appointment and in writing, of the ABIM*
378 *policies and procedures that will affect their eligibility for ABIM*
379 *certification.*

380
381 III.A.4. When averaged over any five-year period, a minimum of 75% of fellows in
382 each program must be graduates of an ACGME-accredited
383 cardiovascular disease program.

384
385 **III.B. Number of Fellows**

386
387 **The program director may not appoint more fellows than approved by the**
388 **Review Committee, unless otherwise stated in the specialty-specific**
389 **requirements. The program's educational resources must be adequate to**
390 **support the number of fellows appointed to the program.**

391
392 **IV. Educational Program**

393
394 **IV.A. The curriculum must contain the following educational components:**

395
396 **IV.A.1. Skills and competencies the fellow will be able to demonstrate at the**
397 **conclusion of the program. The program must distribute these skills**
398 **and competencies to fellow and faculty annually, in either written or**
399 **electronic form. These skills and competencies should be reviewed**
400 **by the fellow at the start of each rotation.**

401
402 **IV.A.2. ACGME Competencies**

403
404 **The program must integrate the following ACGME competencies**
405 **into the curriculum:**

406
407 **IV.A.2.a) Patient Care**

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

- IV.A.2.a).(1) *must demonstrate competence in the practice of health promotion, disease prevention, diagnosis, care, and treatment of patients of each gender, from adolescence to old age, during health and all stages of illness.*
- IV.A.2.a).(2) must demonstrate competence in the prevention, evaluation and management of both inpatients and outpatients with:
 - IV.A.2.a).(2).(a) acute cellular and antibody mediated rejection;
 - IV.A.2.a).(2).(b) acute decompensation of chronic heart failure;
 - IV.A.2.a).(2).(c) cardiac allograft vasculopathy;
 - IV.A.2.a).(2).(d) a cardiac transplant (at least 30 patients, of whom at least five are seen during initial transplant hospitalization and peri-operative management);
 - IV.A.2.a).(2).(e) cytomegalovirus and other opportunistic infections;
 - IV.A.2.a).(2).(f) heart failure secondary to cancer chemotherapy;
 - IV.A.2.a).(2).(g) heart failure and congenital heart disease;
 - IV.A.2.a).(2).(h) heart failure and arrhythmias;
 - IV.A.2.a).(2).(i) heart failure and who are being evaluated for implantable cardioverter-defibrillators (at least 50 patients);
 - IV.A.2.a).(2).(j) heart failure and who are being evaluated for cardiac resynchronization therapy (at least 50 patients);
 - IV.A.2.a).(2).(k) heart failure and other transplanted organs;
 - IV.A.2.a).(2).(l) heart failure and who are on mechanical assist devices (at least 10 patients, of whom at least two are being managed during peri-operative hospitalization);
 - IV.A.2.a).(2).(m) heart failure with dilated or non-dilated left ventricle;
 - IV.A.2.a).(2).(n) heart failure and who are pregnant or recently post-partum;

460	IV.A.2.a).(2).(o)	heart failure and who are from diverse ethnic
461		groups;
462		
463	IV.A.2.a).(2).(p)	hypertension;
464		
465	IV.A.2.a).(2).(q)	hypertrophic cardiomyopathies;
466		
467	IV.A.2.a).(2).(r)	infiltrative and inflammatory cardiomyopathies;
468		
469	IV.A.2.a).(2).(s)	inherited forms of cardiomyopathy;
470		
471	IV.A.2.a).(2).(t)	new onset heart failure;
472		
473	IV.A.2.a).(2).(u)	pre-, post-, and non-cardiac surgery heart failure;
474		
475	IV.A.2.a).(2).(v)	post-transplantation hypertension;
476		
477	IV.A.2.a).(2).(w)	post-transplantation renal insufficiency; and,
478		
479	IV.A.2.a).(2).(x)	pulmonary hypertension.
480		
481	IV.A.2.a).(3)	must demonstrate competence in heart failure evaluation,
482		to include:
483		
484	IV.A.2.a).(3).(a)	applying and interpreting approaches to evaluating
485		symptom severity, functional capacity and health-
486		related quality of life in patients with heart failure;
487		
488	IV.A.2.a).(3).(b)	recognizing clinical features in all forms and
489		etiologies of heart failure;
490		
491	IV.A.2.a).(3).(c)	recognizing the indications for, and interpreting the
492		results of all diagnostic tests and modalities
493		relevant to evaluating and managing patients with,
494		or suspected of having, heart failure or cardiac
495		dysfunction; in particular, recognizing the impact of
496		such testing on the management of these patients;
497		and,
498		
499	IV.A.2.a).(3).(d)	using and interpreting the results of maximal and
500		sub-maximal exercise testing and cardiopulmonary
501		exercise testing.
502		
503	IV.A.2.a).(4)	must demonstrate competence in heart failure
504		management to include:
505		
506	IV.A.2.a).(4).(a)	assigning methods of surveillance for transplant
507		rejection and immune status;
508		
509	IV.A.2.a).(4).(b)	device interrogation and interpretation in patients
510		with implanted cardioverter-defibrillators or

511		implanted cardioverter-defibrillator-cardiac
512		resynchronization therapy devices (at least 100
513		interrogations and interpretations of these devices
514		must be performed);
515		
516	IV.A.2.a).(4).(c)	recognizing the indications for and prescribing non-
517		pharmacologic, non-device treatment modalities
518		including diet and exercise;
519		
520	IV.A.2.a).(4).(d)	recognizing the indications for, prescribing, and
521		monitoring all classes of drugs relevant to patient
522		care; and,
523		
524	IV.A.2.a).(4).(e)	recognizing the indications for and prescribing
525		immunomodulating drugs, and managing their
526		adverse effects, therapeutic levels, and interactions
527		with other drugs.
528		
529	IV.A.2.b)	Medical Knowledge
530		
531		Fellows must demonstrate knowledge of established and
532		evolving biomedical, clinical, epidemiological and social-
533		behavioral sciences, as well as the application of this
534		knowledge to patient care. Fellows:
535		
536	IV.A.2.b).(1)	<i>must demonstrate knowledge of the scientific method of</i>
537		<i>problem solving and evidence-based decision making;</i>
538		
539	IV.A.2.b).(2)	<i>must demonstrate knowledge of indications,</i>
540		<i>contraindications, limitations, complications, techniques,</i>
541		<i>and interpretation of results of those diagnostic and</i>
542		<i>therapeutic procedures integral to the discipline, including</i>
543		<i>the appropriate indications for and use of screening</i>
544		<i>tests/procedures;</i>
545		
546	IV.A.2.b).(3)	must demonstrate knowledge of basic mechanisms of
547		heart failure, to include:
548		
549	IV.A.2.b).(3).(a)	cardiomyocyte biology as it applies to heart failure;
550		
551	IV.A.2.b).(3).(b)	differential diagnosis that includes specific
552		etiologies and exacerbating factors for patients
553		presenting with new onset heart failure and with
554		acute exacerbation of chronic heart failure;
555		
556	IV.A.2.b).(3).(c)	extracellular matrix biology, including the roles of
557		matrix remodeling in the progression of heart
558		failure;
559		
560	IV.A.2.b).(3).(d)	genetics, including common mutations leading to
561		hypertrophic and dilated cardiomyopathies;

562
563 IV.A.2.b).(3).(e) the impact of psychosocial factors on the
564 manifestations, expression, and management of
565 heart failure;
566
567 IV.A.2.b).(3).(f) interpretation of endomyocardial biopsy results with
568 regard to implications for therapy;
569
570 IV.A.2.b).(3).(g) neurohormonal activation;
571
572 IV.A.2.b).(3).(h) pharmacogenomics, specifically as it applies to
573 special-needs patients with heart failure;
574
575 IV.A.2.b).(3).(i) the role and interpretation of hemodynamic
576 monitoring; and,
577
578 IV.A.2.b).(3).(j) ventricular remodeling concepts.

579
580 **IV.A.2.c)**

Practice-based Learning and Improvement

581
582 **Fellows are expected to develop skills and habits to be able**
583 **to meet the following goals:**

584
585 **IV.A.2.c).(1)** **systematically analyze practice using quality**
586 **improvement methods, and implement changes with**
587 **the goal of practice improvement; and**

588
589 **IV.A.2.c).(2)** **locate, appraise, and assimilate evidence from**
590 **scientific studies related to their patients' health**
591 **problems; and**

592
593 IV.A.2.c).(3) apply new contributions to the management and care of
594 their patients.

595
596 **IV.A.2.d)**

Interpersonal and Communication Skills

597
598 **Fellows must demonstrate interpersonal and communication**
599 **skills that result in the effective exchange of information and**
600 **collaboration with patients, their families, and health**
601 **professionals.**

602
603 I.A.1.a).(1) Fellows must demonstrate competence in managing
604 cardiac transplant patients within the context of a team of
605 transplant professionals.

606
607 **IV.A.2.e)**

Professionalism

608
609 **Fellows must demonstrate a commitment to carrying out**
610 **professional responsibilities and an adherence to ethical**
611 **principles.**

612

613	IV.A.2.e).(1)	<i>Fellows must demonstrate:</i>
614		
615	IV.A.2.e).(1).(a)	<i>high standards of ethical behavior, including</i>
616		<i>maintaining appropriate professional boundaries</i>
617		<i>and relationships with other physicians, and other</i>
618		<i>health care team members, avoiding conflicts of</i>
619		<i>interest; and,</i>
620		
621	IV.A.2.e).(1).(b)	<i>a commitment to lifelong learning, and an attitude</i>
622		<i>of caring that is derived from humanistic and</i>
623		<i>professional values.</i>
624		
625	IV.A.2.f)	Systems-based Practice
626		
627		Fellows must demonstrate an awareness of and
628		responsiveness to the larger context and system of health
629		care, as well as the ability to call effectively on other
630		resources in the system to provide optimal health care.
631		
632	IV.A.3.	Curriculum Organization and Fellow Experiences
633		
634	IV.A.3.a)	All 12 months must include clinical experiences and appropriate
635		protected (block or concurrent) time for research.
636		
637	IV.A.3.b)	On average, 25% of each fellow's education should occur in the
638		ambulatory setting.
639		
640	IV.A.3.b).(1)	Fellows should participate in ambulatory patient care that
641		involves a wide variety of patients with heart failure,
642		transplants, and mechanical circulatory support.
643		
644	IV.A.3.c)	<i>Fellows must participate in training using simulation.</i>
645		
646	IV.A.3.d)	<i>The core curriculum must include a didactic program based upon</i>
647		<i>the core knowledge content in the subspecialty area.</i>
648		
649	IV.A.3.d).(1)	<i>The program must afford each fellow an opportunity to</i>
650		<i>review topics covered in conferences that he or she was</i>
651		<i>unable to attend.</i>
652		
653	IV.A.3.d).(2)	<i>Fellows must participate in clinical case conferences,</i>
654		<i>journal clubs, research conferences, and morbidity and</i>
655		<i>mortality or quality improvement conferences.</i>
656		
657	IV.A.3.d).(3)	<i>All core conferences must have at least one faculty</i>
658		<i>member present, and must be scheduled as to ensure</i>
659		<i>peer-peer and peer-faculty interaction.</i>
660		
661	IV.A.3.e)	Fellows must be instructed in practice management relevant to
662		advanced heart failure and transplant cardiology.
663		

664	IV.A.3.f)	Fellows must have clinical experience in:
665		
666	IV.A.3.f).(1)	caring for patients in the context of a multidisciplinary
667		disease management program;
668		
669	IV.A.3.f).(2)	end-of-life care;
670		
671	IV.A.3.f).(3)	evaluating at least 30 patients for cardiac transplant or
672		mechanical assist devices; and,
673		
674	IV.A.3.f).(4)	the management of diagnostic and therapeutic devices
675		used for the evaluation and management of heart failure in
676		the acute and chronic setting.
677		
678	IV.A.3.g)	Procedures and Technical Skills
679		
680	IV.A.3.g).(1)	<i>Direct supervision of procedures performed by each fellow</i>
681		<i>must occur until proficiency has been acquired and</i>
682		<i>documented by the program director.</i>
683		
684	IV.A.3.g).(2)	Faculty members must teach and supervise the fellows in
685		the performance and interpretation of procedures, which
686		must be documented in each fellow's record, including
687		indications, outcomes, diagnoses, and supervisor(s).
688		
689	IV.A.3.g).(3)	All fellows must:
690		
691	IV.A.3.g).(3).(a)	participate in pre-procedural planning, including the
692		indications for a procedure, and the selection of the
693		appropriate procedure or instruments;
694		
695	IV.A.3.g).(3).(b)	demonstrate substantial involvement in post-
696		procedure care; and,
697		
698	IV.A.3.g).(3).(c)	perform at least 30 endomyocardial biopsies.
699		
700	IV.B.	Fellows' Scholarly Activities
701		
702	IV.B.1.	<i>Each program must provide an opportunity for fellows to participate in</i>
703		<i>research or other scholarly activities, including:</i>
704		
705	IV.B.1.a)	<i>a research project (with faculty mentorship); or,</i>
706		
707	IV.B.1.b)	<i>participation with the faculty in the initiation and conduct of clinical</i>
708		<i>trials within the department; or,</i>
709		
710	IV.B.1.c)	<i>participation in quality assurance/quality improvement or process</i>
711		<i>improvement projects.</i>
712		
713	V.	Evaluation
714		

715	V.A.	Fellow Evaluation
716		
717	V.A.1.	Formative Evaluation
718		
719	V.A.1.a)	The faculty must evaluate fellow performance in a timely manner.
720		
721		
722	V.A.1.a).(1)	<i>The faculty must discuss evaluations with the fellow at least every three months.</i>
723		
724		
725	V.A.1.a).(2)	<i>Assessment of procedural competence should include a formal evaluation process and not be based solely on a minimum number of procedures performed.</i>
726		
727		
728		
729	V.A.1.b)	The program must:
730		
731	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;
732		
733		
734		
735		
736		
737	V.A.1.b).(1).(a)	<i>Patient Care</i>
738		
739		<i>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.</i>
740		
741		
742		
743		
744		
745	V.A.1.b).(1).(a).(i)	<i>Each program must define criteria for competence for all required and elective procedures.</i>
746		
747		
748		
749	V.A.1.b).(1).(a).(ii)	<i>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.</i>
750		
751		
752		
753		
754		
755	V.A.1.b).(1).(b)	<i>Medical Knowledge</i>
756		
757		<i>The program must use an objective formative assessment method. The same formative assessment method must be administered at least twice during the program.</i>
758		
759		
760		
761		
762	V.A.1.b).(1).(c)	<i>Practice-based Learning and Improvement</i>
763		
764		<i>The program must use performance data to assess the fellow in:</i>
765		

766		
767	V.A. 1.b).(1).(c).(i)	<i>application of evidence to patient care;</i>
768		
769	V.A. 1.b).(1).(c).(ii)	<i>practice improvement;</i>
770		
771	V.A. 1.b).(1).(c).(iii)	<i>teaching skills involving peers and patients;</i>
772		<i>and,</i>
773		
774	V.A. 1.b).(1).(c).(iv)	<i>scholarship.</i>
775		
776	V.A. 1.b).(1).(d)	<i>Interpersonal and Communication Skills</i>
777		
778		<i>The program must use both direct observation and</i>
779		<i>multi-source evaluation, including patients, peers</i>
780		<i>and non-physician team members, to assess fellow</i>
781		<i>performance in:</i>
782		
783	V.A. 1.b).(1).(d).(i)	<i>communication with patient and family;</i>
784		
785	V.A. 1.b).(1).(d).(ii)	<i>teamwork;</i>
786		
787	V.A. 1.b).(1).(d).(iii)	<i>communication with peers, including</i>
788		<i>transitions in care; and,</i>
789		
790	V.A. 1.b).(1).(d).(iv)	<i>record keeping.</i>
791		
792	V.A. 1.b).(1).(e)	<i>Professionalism</i>
793		
794		<i>The program must use multi-source evaluation,</i>
795		<i>including patients, peers, and non-physician team</i>
796		<i>members, to assess each fellow's:</i>
797		
798	V.A. 1.b).(1).(e).(i)	<i>honesty and integrity;</i>
799		
800	V.A. 1.b).(1).(e).(ii)	<i>ability to meet professional responsibilities;</i>
801		
802	V.A. 1.b).(1).(e).(iii)	<i>ability to maintain appropriate professional</i>
803		<i>relationships with patients and colleagues;</i>
804		<i>and,</i>
805		
806	V.A. 1.b).(1).(e).(iv)	<i>commitment to self-improvement.</i>
807		
808	V.A. 1.b).(1).(f)	<i>Systems-based Practice</i>
809		
810		<i>The program must use multi-source evaluation,</i>
811		<i>including peers and non-physician team members,</i>
812		<i>to assess each fellow's:</i>
813		
814	V.A. 1.b).(1).(f).(i)	<i>ability to provide care coordination,</i>
815		<i>including transition of care;</i>
816		

- 817 V.A. 1.b).(1).(f).(ii) *ability to work in interdisciplinary teams;*
818
819 V.A. 1.b).(1).(f).(iii) *advocacy for quality of care; and,*
820
821 V.A. 1.b).(1).(f).(iv) *ability to identify system problems and*
822 *participate in improvement activities.*
823
824 **V.A.1.b).(2)** **use multiple evaluators (e.g., faculty, peers, patients,**
825 **self, and other professional staff);**
826
827 **V.A.1.b).(3)** **document progressive fellow performance**
828 **improvement appropriate to educational level; and**
829
830 **V.A.1.b).(4)** **provide each fellow with documented semiannual**
831 **evaluation of performance with feedback.**
832
833 **V.A.1.c)** **The evaluation of fellow performance must be accessible for**
834 **review by the fellows, in accordance with institutional policy.**
835
836 **V.A.2.** **Summative Evaluation**
837
838 **The program director must provide a summative evaluation for each**
839 **fellow upon completion of the program. This evaluation must**
840 **become part of the fellow’s permanent record maintained by the**
841 **institution, and must be accessible for review by the fellow in**
842 **accordance with institutional policy. This evaluation must:**
843
844 **V.A.2.a)** **document the fellow’s performance during their education;**
845 **and,**
846
847 **V.A.2.b)** **verify that the fellow has demonstrated sufficient competence**
848 **to enter practice without direct supervision.**
849
850 **V.B.** **Faculty Evaluation**
851
852 **V.B.1.** **At least annually, the program must evaluate faculty performance as**
853 **it relates to the educational program.**
854
855 **V.B.2.** **These evaluations should include a review of the faculty’s clinical**
856 **teaching abilities, commitment to the educational program, clinical**
857 **knowledge, professionalism, and scholarly activities. These**
858 **evaluations must be confidential, and must be reviewed with the**
859 **faculty members annually.**
860
861 **V.B.3.** *Fellows must have the opportunity to provide confidential written*
862 *evaluations of each supervising faculty member at the end of each*
863 *rotation.*
864
865 **V.B.4.** *These evaluations must be reviewed with each faculty member annually.*
866
867 **V.C.** **Program Evaluation and Improvement**

- 868
869 **V.C.1.** **The program must document formal, systematic evaluation of the**
870 **curriculum at least annually. The program must monitor and track**
871 **each of the following areas:**
872
- 873 **V.C.1.a)** **fellow performance;**
874
- 875 **V.C.1.b)** **faculty development;**
876
- 877 V.C.1.c) graduate performance, including performance of program
878 graduates on the certification examination; and,
879
- 880 V.C.1.c).(1) At least 80% of a program’s graduating fellows from the
881 most recently defined five-year period who are eligible
882 should take the ABIM certifying examination.
883
- 884 V.C.1.c).(2) At least 80% of a program’s graduates taking the ABIM
885 certifying examination for the first time during the most
886 recently defined five-year period should pass.
887
- 888 V.C.1.c).(3) At least 80% of the entering fellows should have completed
889 the program when averaged over a five-year period.
890
- 891 **V.C.2.** **If deficiencies are found, the program should prepare a written plan**
892 **of action to document initiatives to improve performance in the**
893 **areas listed in section V.C.1. The action plan should be reviewed**
894 **and approved by the teaching faculty and documented in meeting**
895 **minutes.**
896
- 897 V.C.3 *Representative program personnel, at a minimum to include the program*
898 *director, representative faculty, and one fellow, must review program*
899 *goals and objectives, and the effectiveness with which they are achieved.*
900
- 901 **VI. Fellow Duty Hours in the Learning and Working Environment**
902
- 903 **VI.A. Professionalism, Personal Responsibility, and Patient Safety**
904
- 905 **VI.A.1.** **Programs and sponsoring institutions must educate fellows and**
906 **faculty members concerning the professional responsibilities of**
907 **physicians to appear for duty appropriately rested and fit to provide**
908 **the services required by their patients.**
909
- 910 **VI.A.2.** **The program must be committed to and responsible for promoting**
911 **patient safety and fellow well-being in a supportive educational**
912 **environment.**
913
- 914 **VI.A.3.** **The program director must ensure that fellows are integrated and**
915 **actively participate in interdisciplinary clinical quality improvement**
916 **and patient safety programs.**
917
- 918 **VI.A.4.** **The learning objectives of the program must:**

- 919
920 **VI.A.4.a)** be accomplished through an appropriate blend of supervised
921 patient care responsibilities, clinical teaching, and didactic
922 educational events; and,
923
- 924 **VI.A.4.b)** not be compromised by excessive reliance on fellows to fulfill
925 non-physician service obligations.
926
- 927 **VI.A.5.** The program director and sponsoring institution must ensure a
928 culture of professionalism that supports patient safety and personal
929 responsibility. Fellows and faculty members must demonstrate an
930 understanding and acceptance of their personal role in the
931 following:
932
- 933 **VI.A.5.a)** assurance of the safety and welfare of patients entrusted to
934 their care;
935
- 936 **VI.A.5.b)** provision of patient- and family-centered care;
937
- 938 **VI.A.5.c)** assurance of their fitness for duty;
939
- 940 **VI.A.5.d)** management of their time before, during, and after clinical
941 assignments;
942
- 943 **VI.A.5.e)** recognition of impairment, including illness and fatigue, in
944 themselves and in their peers;
945
- 946 **VI.A.5.f)** attention to lifelong learning;
947
- 948 **VI.A.5.g)** the monitoring of their patient care performance improvement
949 indicators; and,
950
- 951 **VI.A.5.h)** honest and accurate reporting of duty hours, patient
952 outcomes, and clinical experience data.
953
- 954 **VI.A.6.** All fellows and faculty members must demonstrate responsiveness
955 to patient needs that supersedes self-interest. Physicians must
956 recognize that under certain circumstances, the best interests of the
957 patient may be served by transitioning that patient's care to another
958 qualified and rested provider.
959
- 960 **VI.B.** Transitions of Care
961
- 962 **VI.B.1.** Programs must design clinical assignments to minimize the number
963 of transitions in patient care.
964
- 965 **VI.B.2.** Sponsoring institutions and programs must ensure and monitor
966 effective, structured hand-over processes to facilitate both
967 continuity of care and patient safety.
968
- 969 **VI.B.3.** Programs must ensure that fellows are competent in communicating

- 970 with team members in the hand-over process.
971
- 972 **VI.B.4.** The sponsoring institution must ensure the availability of schedules
973 that inform all members of the health care team of attending
974 physicians and fellows currently responsible for each patient's care.
975
- 976 **VI.C.** Alertness Management/Fatigue Mitigation
977
- 978 **VI.C.1.** The program must:
979
- 980 **VI.C.1.a)** educate all faculty members and fellows to recognize the
981 signs of fatigue and sleep deprivation;
982
- 983 **VI.C.1.b)** educate all faculty members and fellows in alertness
984 management and fatigue mitigation processes; and,
985
- 986 **VI.C.1.c)** adopt fatigue mitigation processes to manage the potential
987 negative effects of fatigue on patient care and learning, such
988 as naps or back-up call schedules.
989
- 990 **VI.C.2.** Each program must have a process to ensure continuity of patient
991 care in the event that a fellow may be unable to perform his/her
992 patient care duties.
993
- 994 **VI.C.3.** The sponsoring institution must provide adequate sleep facilities
995 and/or safe transportation options for fellows who may be too
996 fatigued to safely return home.
997
- 998 **VI.D.** Supervision of Fellows
999
- 1000 **VI.D.1.** In the clinical learning environment, each patient must have an
1001 identifiable, appropriately-credentialed and privileged attending
1002 physician (or licensed independent practitioner as approved by each
1003 Review Committee) who is ultimately responsible for that patient's
1004 care.
1005
- 1006 **VI.D.1.a)** This information should be available to fellows, faculty
1007 members, and patients.
1008
- 1009 **VI.D.1.b)** Fellows and faculty members should inform patients of their
1010 respective roles in each patient's care.
1011
- 1012 **VI.D.2.** The program must demonstrate that the appropriate level of
1013 supervision is in place for all fellows who care for patients.
1014
- 1015 Supervision may be exercised through a variety of methods. Some
1016 activities require the physical presence of the supervising faculty
1017 member. For many aspects of patient care, the supervising
1018 physician may be a more advanced fellow. Other portions of care
1019 provided by the fellow can be adequately supervised by the
1020 immediate availability of the supervising faculty member or fellow

1021 physician, either in the institution, or by means of telephonic and/or
1022 electronic modalities. In some circumstances, supervision may
1023 include post-hoc review of fellow-delivered care with feedback as to
1024 the appropriateness of that care.

1025
1026 **VI.D.3. Levels of Supervision**

1027
1028 **To ensure oversight of fellow supervision and graded authority and**
1029 **responsibility, the program must use the following classification of**
1030 **supervision:**

1031
1032 **VI.D.3.a) Direct Supervision – the supervising physician is physically**
1033 **present with the fellow and patient.**

1034
1035 **VI.D.3.b) Indirect Supervision:**

1036
1037 **VI.D.3.b).(1) with direct supervision immediately available – the**
1038 **supervising physician is physically within the hospital**
1039 **or other site of patient care, and is immediately**
1040 **available to provide Direct Supervision.**

1041
1042 **VI.D.3.b).(2) with direct supervision available – the supervising**
1043 **physician is not physically present within the hospital**
1044 **or other site of patient care, but is immediately**
1045 **available by means of telephonic and/or electronic**
1046 **modalities, and is available to provide Direct**
1047 **Supervision.**

1048
1049 **VI.D.3.c) Oversight – the supervising physician is available to provide**
1050 **review of procedures/encounters with feedback provided**
1051 **after care is delivered.**

1052
1053 **VI.D.4. The privilege of progressive authority and responsibility, conditional**
1054 **independence, and a supervisory role in patient care delegated to**
1055 **each fellow must be assigned by the program director and faculty**
1056 **members.**

1057
1058 **VI.D.4.a) The program director must evaluate each fellow’s abilities**
1059 **based on specific criteria. When available, evaluation should**
1060 **be guided by specific national standards-based criteria.**

1061
1062 **VI.D.4.b) Faculty members functioning as supervising physicians**
1063 **should delegate portions of care to fellows, based on the**
1064 **needs of the patient and the skills of the fellows.**

1065
1066 **VI.D.4.c) Fellows should serve in a supervisory role of residents or**
1067 **junior fellows in recognition of their progress toward**
1068 **independence, based on the needs of each patient and the**
1069 **skills of the individual fellow.**

1070
1071 **VI.D.5. Programs must set guidelines for circumstances and events in**

1072 which fellows must communicate with appropriate supervising
1073 faculty members, such as the transfer of a patient to an intensive
1074 care unit, or end-of-life decisions.
1075

1076 **VI.D.5.a)** Each fellow must know the limits of his/her scope of
1077 authority, and the circumstances under which he/she is
1078 permitted to act with conditional independence.
1079

1080 **VI.D.6.** Faculty supervision assignments should be of sufficient duration to
1081 assess the knowledge and skills of each fellow and delegate to
1082 him/her the appropriate level of patient care authority and
1083 responsibility.
1084

1085 **VI.E.** **Clinical Responsibilities**
1086
1087 The clinical responsibilities for each fellow must be based on PGY-level,
1088 patient safety, fellow education, severity and complexity of patient
1089 illness/condition and available support services.
1090

1091 **VI.F.** **Teamwork**
1092
1093 Fellows must care for patients in an environment that maximizes effective
1094 communication. This must include the opportunity to work as a member of
1095 effective interprofessional teams that are appropriate to the delivery of care
1096 in the specialty.
1097

1098 **VI.G.** **Fellow Duty Hours**
1099

1100 **VI.G.1.** **Maximum Hours of Work per Week**
1101
1102 Duty hours must be limited to 80 hours per week, averaged over a
1103 four-week period, inclusive of all in-house call activities and all
1104 moonlighting.
1105

1106 **VI.G.1.a)** **Duty Hour Exceptions**
1107
1108 A Review Committee may grant exceptions for up to 10% or a
1109 maximum of 88 hours to individual programs based on a
1110 sound educational rationale.
1111
1112 The Review Committee for Internal Medicine will not consider
1113 requests for exceptions to the 80-hour limit to the fellows' work
1114 week.
1115

1116 **VI.G.1.a).(1)** **In preparing a request for an exception the program**
1117 **director must follow the duty hour exception policy**
1118 **from the ACGME Manual on Policies and Procedures.**
1119

1120 **VI.G.1.a).(2)** **Prior to submitting the request to the Review**
1121 **Committee, the program director must obtain approval**
1122 **of the institution's GMEC and DIO.**

1123		
1124	VI.G.2.	Moonlighting
1125		
1126	VI.G.2.a)	Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program.
1127		
1128		
1129		
1130	VI.G.2.b)	Time spent by fellows in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.
1131		
1132		
1133		
1134	VI.G.3.	Mandatory Time Free of Duty
1135		
1136		Fellows must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.
1137		
1138		
1139		
1140	VI.G.4.	Maximum Duty Period Length
1141		
1142		Duty periods of fellows may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.
1143		
1144		
1145		
1146		
1147		
1148		
1149	VI.G.4.a)	It is essential for patient safety and fellow education that effective transitions in care occur. Fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
1150		
1151		
1152		
1153		
1154		
1155	VI.G.4.b)	Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
1156		
1157		
1158	VI.G.4.c)	In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.
1159		
1160		
1161		
1162		
1163		
1164		
1165		
1166	VI.G.4.c).(1)	Under those circumstances, the fellow must:
1167		
1168	VI.G.4.c).(1).(a)	appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
1169		
1170		
1171		
1172	VI.G.4.c).(1).(b)	document the reasons for remaining to care for the patient in question and submit that
1173		

1174		documentation in every circumstance to the
1175		program director.
1176		
1177	VI.G.4.c).(2)	The program director must review each submission of
1178		additional service, and track both individual fellow and
1179		program-wide episodes of additional duty.
1180		
1181	VI.G.5.	Minimum Time Off between Scheduled Duty Periods
1182		
1183	VI.G.5.a)	Residents in the final years of education must be prepared to
1184		enter the unsupervised practice of medicine and care for
1185		patients over irregular or extended periods.
1186		
1187		Internal medicine subspecialty fellows are considered to be in the
1188		final years of education.
1189		
1190	VI.G.5.a).(1)	This preparation must occur within the context of the
1191		80-hour, maximum duty period length, and one-day-
1192		off-in-seven standards. While it is desirable that
1193		fellows in their final years of education have eight
1194		hours free of duty between scheduled duty periods,
1195		there may be circumstances when these fellows must
1196		stay on duty to care for their patients or return to the
1197		hospital with fewer than eight hours free of duty.
1198		
1199	VI.G.5.a).(1).(a)	Circumstances of return-to-hospital activities
1200		with fewer than eight hours away from the
1201		hospital by fellows in their final years of
1202		education must be monitored by the program
1203		director.
1204		
1205	VI.G.5.a).(1).(b)	In unusual circumstances, fellows may remain
1206		beyond their scheduled period of duty or return
1207		after their scheduled period of duty to provide care
1208		to a single patient. Justifications for such
1209		extensions of duty are limited to reasons of
1210		required continuity of care for a severely ill or
1211		unstable patient, academic importance of the
1212		events transpiring, or humanistic attention to the
1213		needs of the patient or family. Such episodes
1214		should be rare, must be of the fellows' own
1215		initiative, and need not initiate a new 'off-duty
1216		period' nor require a change in the scheduled 'off-
1217		duty period.'
1218		
1219	VI.G.5.a).(1).(c)	Under such circumstances, the fellow must
1220		appropriately hand over care of all other patients to
1221		the team responsible for their continuing care, and
1222		document the reasons for remaining or returning to
1223		care for the patient in question and submit that
1224		documentation to the program director.

1225
1226 VI.G.5.a).(1).(d) The program director must review each submission
1227 of additional service and track both individual
1228 fellows' and program-wide episodes of additional
1229 duty.
1230

1231 **VI.G.6. Maximum Frequency of In-House Night Float**

1232
1233 **Fellows must not be scheduled for more than six consecutive nights**
1234 **of night float.**
1235

1236 **VI.G.7. Maximum In-House On-Call Frequency**

1237
1238 **Fellows must be scheduled for in-house call no more frequently than**
1239 **every-third-night (when averaged over a four-week period).**
1240

1241 *VI.G.7.a) Internal medicine fellowships must not average in-house call over*
1242 *a four-week period.*
1243

1244 **VI.G.8. At-Home Call**

1245
1246 **VI.G.8.a) Time spent in the hospital by fellows on at-home call must**
1247 **count towards the 80-hour maximum weekly hour limit. The**
1248 **frequency of at-home call is not subject to the every-third-**
1249 **night limitation, but must satisfy the requirement for one-day-**
1250 **in-seven free of duty, when averaged over four weeks.**
1251

1252 **VI.G.8.a).(1) At-home call must not be so frequent or taxing as to**
1253 **preclude rest or reasonable personal time for each**
1254 **fellow.**
1255

1256 **VI.G.8.b) Fellows are permitted to return to the hospital while on at-**
1257 **home call to care for new or established patients. Each**
1258 **episode of this type of care, while it must be included in the**
1259 **80-hour weekly maximum, will not initiate a new "off-duty**
1260 **period".**
1261

1262 ***