

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Critical Care Medicine**

3
4 **Common Program Requirements are in BOLD**

5
6 Effective: July 1, 2012
7

8 **Introduction**
9

10 **Int.A. Residency is an essential dimension of the transformation of the medical**
11 **student to the independent practitioner along the continuum of medical**
12 **education. It is physically, emotionally, and intellectually demanding, and**
13 **requires longitudinally-concentrated effort on the part of the resident.**
14

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

33 **Int.B. Critical care medicine is concerned with the diagnosis, management, and**
34 **prevention of complications in patients who are severely ill and who usually**
35 **require intensive monitoring and/or organ system support. Subspecialty-**
36 **programs must Critical care medicine fellowships provide advanced training-**
37 **education to allow the a fellow to acquire competency in the subspecialty with**
38 **sufficient expertise to act as a primary intensivist or independent consultant.**
39

40 **Int.C. The educational program in critical care medicine must be 24 months in length.**
41

42 **I. Institutions**
43

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

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

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

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

53
54 I.A.1. A critical care medicine fellowship must function as an integral part of an
55 Accreditation Council for Graduate Medical Education (ACGME)-
56 accredited residency program in internal medicine.

57
58 I.A.2. ~~The primary training site should sponsor~~ Located at the primary clinical
59 site, there should be at least three ACGME-accredited subspecialty
60 programs from the following disciplines: in cardiovascular disease,
61 gastroenterology, infectious diseases, nephrology, or pulmonary disease;
62

63 I.A.3. The sponsoring institution ~~re must~~ should sponsor be an ACGME-
64 accredited residency program in general surgery;
65

66 I.A.4. The sponsoring institution must:

67
68 I.A.4.a) establish the critical care medicine fellowship within a department
69 of internal medicine or an administrative unit whose primary
70 mission is the advancement of internal medicine subspecialty
71 education and patient care; and,
72

73 I.A.4.b) ~~ensure that provide~~ the program director ~~is provided with~~
74 ~~adequate salary~~ support for the administrative activities of the
75 fellowship.
76

77 I.A.4.b).(1) The program director must not be required to generate
78 clinical or other income to provide this administrative
79 support.
80

81 I.A.4.b).(2) ~~It is suggested~~ This support should be 25-50% of the
82 program director's salary, or protected time depending on
83 the size of the program.
84

85 I.A.5. The sponsoring institution and participating sites must:

86
87 I.A.5.a) demonstrate that there is a culture of continuous quality
88 improvement in the areas of patient care, patient safety, and
89 education;
90

91 I.A.5.b) demonstrate a commitment to quality patient-centered care and
92 safety, education, research and scholarship sufficient to support
93 the fellowship program; and,
94

95 I.A.5.c) share appropriate inpatient faculty performance data with the
96 program director.
97

98 I.A.5.d) ~~provide fellow compensation, and benefits, faculty, facilities, and~~
99 ~~resources for education, clinical care, and research required for~~
100 ~~accreditation;~~
101

- 102 I.A.5.e) ~~notify the Review Committee within 60-30 days of changes in~~
103 ~~institutional governance, affiliation, or resources that affect the~~
104 ~~educational program as outlined in the Institutional Requirements;~~
105 ~~and~~
106
107 I.A.5.f) provide fellowship positions per year; and in the one or two-year,
108 critical care medicine fellowship with no less than one fellow per
109 year; and
110

111 **I.B. Participating Sites**
112

113 **I.B.1.** There must be a program letter of agreement (PLA) between the
114 program and each participating site providing a required
115 assignment. The PLA must be renewed at least every five years.
116

117 The PLA should:

118
119 **I.B.1.a)** identify the faculty who will assume both educational and
120 supervisory responsibilities for fellows;
121

122 **I.B.1.b)** specify their responsibilities for teaching, supervision, and
123 formal evaluation of fellows, as specified later in this
124 document;
125

126 **I.B.1.c)** specify the duration and content of the educational
127 experience; and,
128

129 **I.B.1.d)** state the policies and procedures that will govern fellow
130 education during the assignment.
131

132 **I.B.2.** The program director must submit any additions or deletions of
133 participating sites routinely providing an educational experience,
134 required for all fellows, of one month full time equivalent (FTE) or
135 more through the Accreditation Council for Graduate Medical
136 Education (ACGME) Accreditation Data System (ADS).
137

138 **II. Program Personnel and Resources**
139

140 **II.A. Program Director**
141

142 **II.A.1.** There must be a single program director with authority and
143 accountability for the operation of the program. The sponsoring
144 institution's GMEC must approve a change in program director. After
145 approval, the program director must submit this change to the
146 ACGME via the ADS.
147

148 **II.A.2.** The program director should continue in his or her position for a
149 length of time adequate to maintain continuity of leadership and
150 program stability.
151

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

202		
203	II.A.4.i)	provide verification of fellowship education for all fellows, including those who leave the program prior to completion;
204		
205		
206	II.A.4.j)	implement policies and procedures consistent with the institutional and program requirements for fellow duty hours and the working environment, including moonlighting, and, to that end, must:
207		
208		
209		
210		
211	II.A.4.j).(1)	distribute these policies and procedures to the fellows and faculty;
212		
213		
214	II.A.4.j).(2)	monitor fellow duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
215		
216		
217		
218	II.A.4.j).(3)	adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and
219		
220		
221	II.A.4.j).(4)	if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.
222		
223		
224		
225	II.A.4.k)	monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
226		
227		
228		
229	II.A.4.l)	comply with the sponsoring institution's written policies and procedures, including those specified in Institutional Requirements, for selection, evaluation and promotion of fellows, disciplinary action, and supervision of fellows;
230		
231		
232		
233		
234	II.A.4.m)	be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;
235		
236		
237		
238	II.A.4.n)	obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:
239		
240		
241		
242	II.A.4.n).(1)	all applications for ACGME accreditation of new programs;
243		
244		
245	II.A.4.n).(2)	changes in fellow complement;
246		
247	II.A.4.n).(3)	major changes in program structure or length of training;
248		
249		
250	II.A.4.n).(4)	progress reports requested by the Review Committee;
251		

252	II.A.4.n).(5)	responses to all proposed adverse actions;
253		
254	II.A.4.n).(6)	requests for increases or any change to fellow duty hours;
255		
256		
257	II.A.4.n).(7)	voluntary withdrawals of ACGME-accredited programs;
258		
259		
260	II.A.4.n).(8)	requests for appeal of an adverse action;
261		
262	II.A.4.n).(9)	appeal presentations to a Board of Appeal or the ACGME; and
263		
264		
265	II.A.4.n).(10)	proposals to ACGME for approval of innovative educational approaches.
266		
267		
268	II.A.4.o)	obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:
269		
270		
271		
272	II.A.4.o).(1)	program citations; and/or
273		
274	II.A.4.o).(2)	request for changes in the program that would have significant impact, including financial, on the program or institution.
275		
276		
277		
278	II.A.4.p)	be responsible for monitoring fellow stress, including mental or emotional conditions inhibiting performance or learning, and drug- or alcohol-related dysfunction;
279		
280		
281		
282	II.A.4.p).(1)	Both The program director and faculty should <u>provide access to</u> be sensitive to the need for timely provision of confidential counseling and psychological support services to fellows.
283		
284		
285		
286		
287	II.A.4.p).(2)	Situations that demand excessive service or that consistently produce undesirable stress on fellows must be evaluated and modified.
288		
289		
290		
291	II.A.4.q)	<u>ensure that fellows' service responsibilities are limited to patients for whom the teaching service has diagnostic and therapeutic responsibility;</u>
292		
293		
294		
295	II.A.4.r)	dedicate an average of 20 hours per week of his or her professional effort to the internal medicine subspecialty program fellowship , including with sufficient time for administration of the program; and receive institutional support for that administrative time.
296		
297		
298		
299		
300		
301	II.A.4.s)	participate in academic societies and in educational programs

- 302 designed to enhance his or her educational and administrative
303 skills;
304
305 II.A.4.t) have a reporting relationship with the program director of the
306 ~~parent~~ internal medicine residency program to ensure compliance
307 with the ACGME accreditation standards;
308
309 II.A.4.u) be available ~~located~~ at the primary principal clinical site; and
310
311 II.A.4.v) verify satisfactory completion of previous ACGME-accredited
312 internal medicine education for fellows who are graduates of
313 ACGME-accredited emergency medicine programs.
314

315 **II.B. Faculty**

316
317 **II.B.1. At each participating site, there must be a sufficient number of**
318 **faculty with documented qualifications to instruct and supervise all**
319 **fellows at that location.**

320
321 **The faculty must:**

322
323 **II.B.1.a) devote sufficient time to the educational program to fulfill**
324 **their supervisory and teaching responsibilities; and to**
325 **demonstrate a strong interest in the education of fellows;**
326 **and,**

327
328 **II.B.1.b) administer and maintain an educational environment**
329 **conducive to educating fellows in each of the ACGME**
330 **competency areas.**

331
332 **II.B.2. The physician faculty must have current certification in the**
333 **subspecialty by the American Board of Internal Medicine, or possess**
334 **qualifications acceptable by the Review Committee.**

335
336 **II.B.3. The physician faculty must possess current medical licensure and**
337 **appropriate medical staff appointment.**

338
339 **II.B.4. The nonphysician faculty must have appropriate qualifications in**
340 **their field and hold appropriate institutional appointments.**

341
342 **II.B.5. The faculty must establish and maintain an environment of inquiry**
343 **and scholarship with an active research component.**

344
345 **II.B.5.a) The faculty must regularly participate in organized clinical**
346 **discussions, rounds, journal clubs, and conferences.**

347
348 **II.B.5.b) Some members of the faculty should also demonstrate**
349 **scholarship by one or more of the following:**

350
351 **II.B.5.b).(1) peer-reviewed funding;**

352
353 **II.B.5.b).(2)** **publication of original research or review articles in**
354 **peer-reviewed journals or chapters in textbooks;**
355
356 **II.B.5.b).(3)** **publication or presentation of case reports or clinical**
357 **series at local, regional, or national professional and**
358 **scientific society meetings; or,**
359
360 **II.B.5.b).(4)** **participation in national committees or educational**
361 **organizations.**
362
363 **II.B.5.c)** **Faculty should encourage and support fellows in scholarly**
364 **activities.**
365
366 II.B.6. The physician faculty must meet professional standards of ethical
367 behavior.
368
369 II.B.7. Key Clinical Faculty
370
371 In addition to the program director, each program must have at least two
372 Key Clinical Faculty (KCF) members at the primary training site. KCF are
373 attending physicians who dedicate, on average, 10 hours per week
374 throughout the year to the ~~training~~ program. For programs with more than
375 three fellows, ~~enrolled during the accredited portion of the training~~
376 ~~program, a ratio of KCF to fellows of at least 1:1~~ there must be at least
377 one KCF for every fellow must be maintained.
378
379 II.B.7.a) Key Clinical Faculty Qualifications:
380
381 II.B.7.a).(1) KCF must be active clinicians with ~~broad~~ knowledge of,
382 experience with, and commitment to critical care medicine
383 as a discipline, ~~and.~~
384
385 II.B.7.a).(2) KCF must have current ABIM certification in critical care
386 medicine.
387
388 II.B.7.b) Key Clinical Faculty Responsibilities:
389
390 II.B.7.b).(1) In addition to the responsibilities of all individual faculty,
391 members, the KCF ~~with and~~ the program director are
392 responsible for the planning, implementation, monitoring,
393 and evaluation of the fellows' clinical and research ~~training~~
394 education.
395
396 II.B.7.b).(2) ~~The majority of key clinical faculty~~ At least 50% of the
397 KCF must demonstrate evidence of productivity in the
398 scholarship, specifically, peer-reviewed funding;
399 publication of original research, review articles, editorials,
400 or case reports in peer-reviewed journals; or chapters in
401 textbooks, as defined in II.B.5.b.(1) or (2) above
402

- 403 II.B.7.b).(3) At least one of the KCF must:
404
405 II.B.7.b).(3).(a) be knowledgeable in the evaluation and
406 assessment of the ACGME competencies; and,
407
408 II.B.7.b).(3).(b) spend significant time in the evaluation of fellows,
409 including the direct observation of fellows with
410 patients.
411
412 II.B.7.b).(4) Appointment of one KCF to be an associate program
413 director is suggested.
414
415 II.B.8. ~~All~~ Clinical faculty members should participate in ~~prescribed~~ faculty
416 development programs designed to enhance the effectiveness of their
417 teaching.
418
419 II.B.9. Other Faculty
420
421 II.B.9.a) ~~American Board of Internal Medicine~~ ABIM-certified clinical faculty
422 members in cardiology, gastroenterology, hematology, infectious
423 disease, nephrology, oncology, and pulmonary disease, must
424 participate in the ~~educational~~ program.
425
426 II.B.9.b) Faculty from ~~several related disciplines, such as~~ anesthesiology,
427 cardiovascular surgery, emergency medicine, ~~general~~ neurology,
428 neurosurgery, obstetrics- and gynecology, orthopaedic surgery,
429 surgery, thoracic surgery, urology, and vascular surgery ~~must~~
430 should be available to participate in the ~~training program-~~
431 education of fellows.
432
433 **II.C. Other Program Personnel**
434
435 **The institution and the program must jointly ensure the availability of all**
436 **necessary professional, technical, and clerical personnel for the effective**
437 **administration the program.**
438
439 II.C.1. There must be services available from other health care professionals,
440 including dietitians, language interpreters, nurses, occupational
441 therapists, physical therapists, and social workers.
442
443 II.C.2. Personnel must include ~~specialty-trained~~ nurses and technicians who are
444 skilled in critical care instrumentation, respiratory function, and laboratory
445 medicine.
446
447 II.C.3. There must be ~~ensure the availability of~~ appropriate and timely
448 consultation from other specialties.
449
450 **II.D. Resources**
451
452 **The institution and the program must jointly ensure the availability of**
453 **adequate resources for fellow education, as defined in the specialty**

454 **program requirements.**

455
456 II.D.1. Space and Equipment

457
458 There must be space and equipment for the educational program,
459 including meeting rooms, classrooms, examination rooms, computers,
460 visual and other educational aids, and work/study space.

461
462 II.D.2. Facilities

463
464 II.D.2.a) Inpatient systems must be in place to prevent fellows from
465 performing routine clerical functions, such as scheduling tests and
466 appointments, and retrieving records and letters.

467
468 II.D.2.b) Fellows must have clinical experiences in efficient, effective
469 ambulatory and inpatient care settings. The sponsoring institution
470 must provide the broad range of facilities and clinical support
471 services required to provide comprehensive care of adult patients.

472
473 II.D.2.c) Fellows must have access to a lounge facility during assigned
474 duty hours.

475
476 II.D.2.d) When fellows are assigned night duty in the hospital, assigned
477 night duty, or called in from home, they must be provided with on-
478 call facilities that are convenient and that afford privacy, safety,
479 and a restful environment with a secure space for their
480 belongings.

481
482 II.D.2.e) There must be facilities must be adequate to care for patients with
483 acute myocardial infarction, severe trauma, shock, recent open
484 heart surgery, recent major thoracic or abdominal surgery, and
485 severe neurologic and neurosurgical conditions.

486
487 II.D.3. Laboratory and Imaging Services

488
489 The following must be available at the primary clinical site:

490
491 II.D.3.a) A supporting laboratory must be available to provide that
492 provides complete and prompt laboratory evaluation;

493
494 II.D.3.b) timely bedside imaging services available to for patients in the
495 critical care units; and,

496
497 II.D.3.c) computed tomography (CT) imaging, including CT angiography-
498 must be available;

499
500 II.D.4. Other Facilities, Resources, or Support Services

501
502 II.D.4.a) The following must be available:

503
504 II.D.4.a).(1) an active open heart surgery program;

- 505
506 II.D.4.a).(2) an active emergency service ~~must be available~~;
- 507
508 II.D.4.a).(3) post-operative care and respiratory care services ~~must be~~
509 ~~available~~;
- 510
511 II.D.4.a).(4) nutritional support services ~~must be available~~;
- 512
513 II.D.4.a).(5) ~~The necessary equipment~~ necessary to care for critically-ill
514 ~~patients must be available~~; and.
- 515
516 II.D.4.b) ~~The Critical~~ care unit(s) ~~must be~~ located in a designated area
517 within the hospital, and ~~must be~~ constructed and designed
518 specifically for the care of critically-ill patients.
- 519
520 II.D.4.b).(1) Whether operating in separate locations or in combined
521 facilities, the program must provide the equivalent of a
522 medical intensive care unit (MICU), a surgical intensive
523 care unit (SICU), and a coronary intensive care unit
524 (CICU).
- 525
526 II.D.4.b).(2) The MICU or its equivalent must be at the primary ~~training-~~
527 ~~clinical~~ site, and should be the focus of a teaching service-
528 ~~in which the program director in critical care medicine is~~
529 ~~responsible for the educational program~~;
- 530
531 II.D.4.c) ~~There should be a close liaison with~~ Other services should be
532 available, including anesthesiology, laboratory medicine, and,
533 radiology.
- 534
535 II.D.5. Medical Records
- 536
537 Access to an electronic health record should be provided. In the absence
538 of an existing electronic health record, institutions must demonstrate
539 institutional commitment to its development and progress toward its
540 implementation.
- 541
542 II.D.6. Patient Population
- 543
544 II.D.6.a) The patient population must have a variety of clinical problems
545 and stages of diseases.
- 546
547 II.D.6.b) Because critical care medicine is multidisciplinary in nature, the
548 program must provide opportunities to manage adult patients with
549 a wide variety of serious illnesses and injuries requiring treatment
550 in a critical care setting.
- 551
552 II.D.6.c) There must be patients of each gender ~~both sexes~~, with a broad
553 age range, including geriatric patients.
- 554
555 II.D.6.d) *A sufficient number* of patients must be available to enable ~~ensure~~

556 ~~adequate inpatient and ambulatory experience for each fellow to~~
557 ~~achieve the required educational outcomes.~~

558
559 II.D.6.e) Provide There must be an average daily census of at least five
560 patients per fellow during assignments to critical care units.
561

562 **II.E. Medical Information Access**

563
564 **Fellows must have ready access to specialty-specific and other appropriate**
565 **reference material in print or electronic format. Electronic medical literature**
566 **databases with search capabilities should be available.**
567

568 **III. Fellow Appointments**

569
570 **III.A. Eligibility Criteria**

571
572 **The program director must comply with the criteria for fellow eligibility as**
573 **specified in the Institutional Requirements.**
574

575 III.A.1. To be eligible for appointment at the F1 level, Prior to appointment in the
576 fellowship program, fellows should have completed an ACGME-
577 accredited internal medicine education program or an ACGME-accredited
578 emergency medicine program.
579

580 III.A.2. ~~A fellow may enter a 1-year training program if he/she has~~ To be eligible
581 for appointment at the F2 level to a 12-month education program, fellows
582 must have completed a two- or three-year ACGME-accredited internal
583 medicine subspecialty fellowship.
584

585 III.A.3. Fellows from non-ACGME-accredited internal medicine education-
586 programs must have at least three years of internal medicine education
587 prior to starting the fellowship.
588

589 III.A.4. Fellows from ACGME-accredited emergency medicine programs should
590 have completed at least six months of direct patient care experience in
591 internal medicine, of which at least three months must have been in a
592 medical intensive care unit.
593

594 III.A.5. When averaged over any five-year period, a minimum of 75% of fellows in
595 each subspecialty training program must be graduates of an ACGME-
596 accredited internal medicine training program. Non-ACGME internal-
597 medicine trained fellows must have at least three years of internal-
598 medicine training prior to starting fellowship.
599

600 III.A.6. The program director must inform non-ACGME trained applicants from
601 non-ACGME-accredited programs, prior to appointment and in writing, of
602 the ABIM policies and procedures that may will affect the fellow's their
603 eligibility for ABIM certification.
604

605 **III.B. Number of Fellows**

606

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

611
612 III.B.1. *The number of available fellow positions in the program must be at least*
613 *one per year. ~~The minimum number of fellow positions in the training~~*
614 *~~program fellowship must not be less than the number of accredited~~*
615 *~~training years in the program.~~*

616
617 **III.C. Fellow Transfers**

618
619 **III.C.1. Before accepting a fellow who is transferring from another program,**
620 **the program director must obtain written or electronic verification of**
621 **previous educational experiences and a summative competency-**
622 **based performance evaluation of the transferring fellow.**

623
624 **III.C.2. A program director must provide timely verification of fellowship**
625 **education and summative performance evaluations for fellows who**
626 **leave the program prior to completion.**

627
628 **III.D. Appointment of Fellows and Other Students**

629
630 **The presence of other learners (including, but not limited to, residents from**
631 **other specialties, subspecialty fellows, PhD students, and nurse**
632 **practitioners) in the program must not interfere with the appointed fellows'**
633 **education. The program director must report the presence of other learners**
634 **to the DIO and GMEC in accordance with sponsoring institution guidelines.**

635
636 **IV. Educational Program**

637
638 **IV.A. The curriculum must contain the following educational components:**

639
640 **IV.A.1. Overall educational goals for the program, which the program must**
641 **distribute to fellows and faculty annually;**

642
643 **IV.A.2. Competency-based goals and objectives for each assignment at**
644 **each educational level, which the program must distribute to fellows**
645 **and faculty annually, in either written or electronic form. These**
646 **should be reviewed by the fellow at the start of each rotation;**

647
648 **IV.A.3. Regularly scheduled didactic sessions;**

649
650 IV.A.3.a) The curriculum must include a didactic program based upon the
651 core knowledge content in the subspecialty area.

652
653 IV.A.3.a).(1) The program must afford each fellow an opportunity to
654 review topics covered in conferences that they were
655 unable to attend.

656

- 657 IV.A.3.a).(2) Fellows must participate in clinical case conferences,
658 journal clubs, research conferences, and morbidity and
659 mortality or quality improvement conferences.
660
- 661 IV.A.3.a).(3) All core conferences must have at least one faculty
662 member present and must be scheduled as to ensure
663 peer-peer and peer-faculty interaction.
664
- 665 IV.A.3.b) Patient-based teaching must include direct interaction between
666 fellows and ~~attendings~~ faculty members, bedside teaching,
667 discussion of pathophysiology, and the use of current evidence in
668 diagnostic and therapeutic decisions. The teaching must be:
669
- 670 IV.A.3.b).(1) formally conducted on all inpatient and consultative
671 services; and,
672
- 673 IV.A.3.b).(2) conducted with a frequency and duration sufficient to
674 ensure a meaningful and continuous teaching relationship
675 between the assigned supervising faculty member(s)
676 ~~teaching attending~~ and fellows.
677
- 678 IV.A.3.c) Fellows must receive instruction in practice management relevant
679 to critical care medicine.
680
- 681 **IV.A.4. Delineation of fellow responsibilities for patient care, progressive**
682 **responsibility for patient management, and supervision of fellows**
683 **over the continuum of the program;**
684
- 685 **IV.A.5. ACGME Competencies**
686
- 687 **The program must integrate the following ACGME competencies**
688 **into the curriculum:**
689
- 690 **IV.A.5.a) Patient Care**
691
- 692 **Fellows must be able to provide patient care that is**
693 **compassionate, appropriate, and effective for the treatment of**
694 **health problems and the promotion of health. Fellows:**
695
- 696 IV.A.5.a).(1) must demonstrate competence in the practice of health
697 promotion, disease prevention, diagnosis, care, and
698 treatment of patients of each gender, from adolescence to
699 old age, during health and all stages of illness.
700
- 701 IV.A.5.a).(2) must demonstrate competence in the prevention,
702 evaluation, and management of patients with:
703
- 704 IV.A.5.a).(2).(a) acute lung injury, including radiation, inhalation,
705 and trauma;
706
- 707 IV.A.5.a).(2).(b) acute metabolic disturbances, including

708		overdosages and intoxication syndromes;
709		
710	IV.A.5.a).(2).(c)	anaphylaxis and acute allergic reactions in the critical care unit;
711		
712		
713	IV.A.5.a).(2).(d)	cardiovascular diseases in <u>the</u> critical care unit;
714		
715	IV.A.5.a).(2).(e)	circulatory failure;
716		
717	IV.A.5.a).(2).(f)	end-of-life issues and palliative care; and
718		
719	IV.A.5.a).(2).(g)	hypertensive emergencies;
720		
721	IV.A.5.a).(2).(h)	immunosuppressed conditions in the critical care unit;
722		
723		
724	IV.A.5.a).(2).(i)	metabolic, nutritional, and endocrine effects of critical illness, hematologic and coagulation disorders associated with critical illness;
725		
726		
727		
728	IV.A.5.a).(2).(j)	multi-organ system failure;
729		
730	IV.A.5.a).(2).(k)	perioperative critically-ill patients, to <u>including</u> hemodynamic and ventilatory support;
731		
732		
733	IV.A.5.a).(2).(l)	renal disorders in the critical care unit, including electrolyte and acid-base disturbance and acute renal failure;
734		
735		
736		
737	IV.A.5.a).(2).(m)	respiratory failure, including the acute respiratory distress syndrome, acute and chronic respiratory failure in obstructive lung diseases, and neuromuscular respiratory drive disorders;
738		
739		
740		
741		
742	IV.A.5.a).(2).(n)	sepsis and sepsis syndrome;
743		
744	IV.A.5.a).(2).(o)	severe organ dysfunction resulting in critical illness, to <u>including</u> disorders of the gastrointestinal, neurologic, endocrine, hematologic, musculoskeletal, and immune systems, as well as infections and malignancies; and,
745		
746		
747		
748		
749		
750	IV.A.5.a).(2).(p)	shock syndromes.
751		
752	IV.A.5.a).(3)	<u>must demonstrate competence in</u> interpreting data derived from various bedside devices commonly employed to monitor patients;
753		
754		
755		
756	IV.A.5.a).(4)	must demonstrate competence in <u>procedural and technical skills, including: the following:</u>
757		
758		

759	IV.A.5.a).(4).(a)	airway management;
760		
761	IV.A.5.a).(4).(b)	the use of a variety of positive pressure ventilatory
762		modes, including:
763		
764	IV.A.5.a).(4).(b).(i)	initiation and maintenance <u>of</u> , and weaning
765		<u>off of</u> , ventilatory support;
766		
767	IV.A.5.a).(4).(b).(ii)	respiratory care techniques; and,
768		
769	IV.A.5.a).(4).(b).(iii)	withdrawal of mechanical ventilatory
770		support.
771		
772	IV.A.5.a).(4).(c)	the use of reservoir masks and continuous positive
773		airway pressure masks for delivery of supplemental
774		oxygen, humidifiers, nebulizers, and incentive
775		spirometry;
776		
777	IV.A.5.a).(4).(d)	therapeutic flexible fiber-optic bronchoscopy
778		procedures <u>limited to indications for therapeutic</u>
779		<u>removal of airway secretions, diagnostic aspiration</u>
780		<u>of airway secretions or lavaged fluid, or airway</u>
781		<u>management (each fellow must perform a minimum</u>
782		<u>of 50 such procedures);</u>
783		
784	IV.A.5.a).(4).(e)	diagnostic and therapeutic procedures, including
785		paracentesis, lumbar puncture, thoracentesis,
786		endotracheal intubation, and related procedures;
787		
788	IV.A.5.a).(4).(f)	<u>use of</u> chest tubes and drainage systems;
789		
790	IV.A.5.a).(4).(g)	insertion of arterial, central venous, and pulmonary
791		artery balloon flotation catheters;
792		
793	IV.A.5.a).(4).(h)	operation of bedside hemodynamic monitoring
794		systems;
795		
796	IV.A.5.a).(4).(i)	emergency cardioversion;
797		
798	IV.A.5.a).(4).(j)	interpretation of intracranial pressure monitoring;
799		
800	IV.A.5.a).(4).(k)	nutritional support;
801		
802	IV.A.5.a).(4).(l)	<u>use of ultrasound techniques to perform</u>
803		<u>thoracentesis and place intravascular and</u>
804		<u>intracavitary tubes and catheters;</u> and,
805		
806	IV.A.5.a).(4).(m)	use of transcutaneous pacemakers.
807		

IV.A.5.b)

Medical Knowledge

809

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

- 810
811
812
813
814
- 815 IV.A.5.b).(1) must demonstrate knowledge of the scientific method of
816 problem solving and evidence-based decision making;~~a~~
817 commitment to lifelong learning; ~~and an attitude of caring~~
818 derived from humanistic and professional values;
819
- 820 IV.A.5.b).(2) must develop demonstrate knowledge understanding of
821 indications, contraindications, limitations, complications,
822 techniques, and interpretation of results of those diagnostic
823 and therapeutic procedures integral to critical care
824 medicine the discipline, including:
825
- 826 IV.A.5.b).(2).(a) pericardiocentesis; ~~and~~
827
- 828 IV.A.5.b).(2).(b) the indications, contraindications and complications
829 of placement of percutaneous tracheostomies;
830
- 831 IV.A.5.b).(2).(c) imaging techniques commonly employed in the
832 evaluation of patients with critical illness, including
833 the use of ultrasound;
834
- 835 IV.A.5.b).(2).(d) the appropriate indications for and use of screening
836 tests/ and procedures; and
837
- 838 IV.A.5.b).(2).(e) renal replacement therapy;
839
- 840 IV.A.5.b).(3) are expected to must demonstrate knowledge of
841 appropriate to the practice of critical care medicine in each
842 of the following areas:
843
- 844 IV.A.5.b).(3).(a) the basic sciences, with particular emphasis on
845 biochemistry and physiology, including cell and
846 molecular biology and immunology, as they relate
847 to critical care medicine;
848
- 849 IV.A.5.b).(3).(b) the appropriate indications for and use of screening
850 tests/procedures;
851
- 852 IV.A.5.b).(3).(c) renal replacement therapy;
853
- 854 IV.A.5.b).(3).(d) the ethical, economic and legal aspects of critical
855 illness;
856 IV.A.5.b).(3).(e) the psychosocial and emotional effects of critical
857 illness on patients and their families;
858
- 859 IV.A.5.b).(3).(f) the recognition and management of the critically-ill
860 from disasters, including those caused by chemical

861		and biological agents inhalation, and trauma;
862		
863	IV.A.5.b).(3).(g)	the use of paralytic agents and sedative and analgesic drugs in <u>the</u> critical care unit; and,
864		
865	IV.A.5.b).(3).(h)	detection and prevention of iatrogenic and nosocomial problems in critical care medicine;
866		
867		
868	IV.A.5.b).(3).(i)	Fellows must acquire knowledge regarding monitoring and supervising special services,
869		including:
870		
871		
872	IV.A.5.b).(3).(i).(i)	respiratory care units, and,
873		
874	IV.A.5.b).(3).(i).(ii)	respiratory care techniques and services;
875		and,
876		
877	IV.A.5.b).(3).(j)	pharmacokinetics, pharmacodynamics, and drug metabolism and excretion in critical illness;
878		
879		
880	IV.A.5.c)	Practice-based Learning and Improvement
881		
882		Fellows must demonstrate the ability to investigate and
883		evaluate their care of patients, to appraise and assimilate
884		scientific evidence, and to continuously improve patient care
885		based on constant self-evaluation and life-long learning.
886		Fellows are expected to develop skills and habits to be able
887		to meet the following goals:
888		
889	IV.A.5.c).(1)	identify strengths, deficiencies, and limits in one's
890		knowledge and expertise;
891		
892	IV.A.5.c).(2)	set learning and improvement goals;
893		
894	IV.A.5.c).(3)	identify and perform appropriate learning activities;
895		
896	IV.A.5.c).(4)	systematically analyze practice, using quality
897		improvement methods, and implement changes with
898		the goal of practice improvement;
899		
900	IV.A.5.c).(5)	incorporate formative evaluation feedback into daily
901		practice;
902		
903	IV.A.5.c).(6)	locate, appraise, and assimilate evidence from
904		scientific studies related to their patients' health
905		problems;
906		
907	IV.A.5.c).(7)	use information technology to optimize learning;
908		
909	IV.A.5.c).(8)	participate in the education of patients, families,
910		students, fellows and other health professionals; and,

911
912 IV.A.5.c).(9) obtain procedure-specific informed consent by competently
913 educating patients about rationale, technique, and
914 complications of procedures.

915
916 **IV.A.5.d) Interpersonal and Communication Skills**
917
918 **Fellows must demonstrate interpersonal and communication**
919 **skills that result in the effective exchange of information and**
920 **collaboration with patients, their families, and health**
921 **professionals. Fellows are expected to:**

922
923 **IV.A.5.d).(1) communicate effectively with patients, families, and**
924 **the public, as appropriate, across a broad range of**
925 **socioeconomic and cultural backgrounds;**

926
927 **IV.A.5.d).(2) communicate effectively with physicians, other health**
928 **professionals, and health related agencies;**

929
930 **IV.A.5.d).(3) work effectively as a member or leader of a health care**
931 **team or other professional group;**

932
933 **IV.A.5.d).(4) act in a consultative role to other physicians and**
934 **health professionals; and,**

935
936 **IV.A.5.d).(5) maintain comprehensive, timely, and legible medical**
937 **records, if applicable.**

938
939 **IV.A.5.e) Professionalism**
940
941 **Fellows must demonstrate a commitment to carrying out**
942 **professional responsibilities and an adherence to ethical**
943 **principles. Fellows are expected to demonstrate:**

944
945 **IV.A.5.e).(1) compassion, integrity, and respect for others;**

946
947 **IV.A.5.e).(2) responsiveness to patient needs that supersedes self-**
948 **interest;**

949
950 **IV.A.5.e).(3) respect for patient privacy and autonomy;**

951
952 **IV.A.5.e).(4) accountability to patients, society and the profession;**

953
954 **IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient**
955 **population, including but not limited to diversity in**
956 **gender, age, culture, race, religion, disabilities, and**
957 **sexual orientation;**

958
959 **IV.A.5.e).(6) high standards of ethical behavior, including maintaining**
960 **appropriate professional boundaries and relationships with**

961 other physicians, and avoiding conflicts of interest; and,

962
963 IV.A.5.e).(7) a commitment to lifelong learning, and an attitude of caring
964 derived from humanistic and professional values.

965
966 **IV.A.5.f) Systems-based Practice**

967
968 **Fellows must demonstrate an awareness of and**
969 **responsiveness to the larger context and system of health**
970 **care, as well as the ability to call effectively on other**
971 **resources in the system to provide optimal health care.**
972 **Fellows are expected to:**

973
974 **IV.A.5.f).(1) work effectively in various health care delivery**
975 **settings and systems relevant to their clinical**
976 **specialty;**

977
978 **IV.A.5.f).(2) coordinate patient care within the health care system**
979 **relevant to their clinical specialty;**

980
981 **IV.A.5.f).(3) incorporate considerations of cost awareness and**
982 **risk-benefit analysis in patient and/or population-**
983 **based care as appropriate;**

984
985 **IV.A.5.f).(4) advocate for quality patient care and optimal patient**
986 **care systems;**

987
988 **IV.A.5.f).(5) work in interprofessional teams to enhance patient**
989 **safety and improve patient care quality;**

990
991 **IV.A.5.f).(6) participate in identifying system errors and**
992 **implementing potential systems solutions;**

993
994 IV.A.5.f).(7) ~~Fellows must participate in and become knowledgeable-~~
995 ~~concerning quality improvement and patient safety~~
996 ~~activities in the intensive care unit (ICU); and.~~

997
998 IV.A.5.f).(8) acquire skills required to organize, administer, and direct a
999 critical care unit.

1000
1001 IV.A.6. Curriculum Organization and Fellow Experiences

1002
1003 IV.A.6.a) A minimum of 12 months must be devoted to clinical experiences-
1004 in critical care.

1005
1006 IV.A.6.a).(1) At least six months must be devoted to the care of
1007 critically-ill medical patients (i.e., MICU/CICU or
1008 equivalent);

1009
1010 IV.A.6.a).(1).(a) This required MICU/CICU experience may be

1011		<u>reduced up to three months by equivalent (month</u>
1012		<u>for month) ICU experience completed during a</u>
1013		<u>previous two- to three-year ACGME-accredited</u>
1014		<u>internal medicine subspecialty fellowship.</u>
1015		
1016	IV.A.6.a).(2)	At least three months must be devoted to the care of
1017		critically-ill non-medical patients (i.e., SICU, Burn Unit,
1018		Transplant Unit, Neurointensive Care, or equivalent).
1019		
1020	IV.A.6.a).(2).(a)	<u>This experience should consist of at least one</u>
1021		<u>month of direct patient care activity, with the</u>
1022		<u>remainder being fulfilled with either consultative</u>
1023		<u>activities or with direct care of such patients.</u>
1024		
1025	IV.A.6.b)	<u>Fellows entering at the F1 level who have completed an ACGME-</u>
1026		<u>accredited emergency medicine program, but have not completed</u>
1027		<u>the prerequisite clinical experiences in internal medicine described</u>
1028		<u>in Section III.A.4., must complete these experiences during the</u>
1029		<u>beginning of the F1 year prior to being allowed to supervise any</u>
1030		<u>internal medicine residents.</u>
1031		
1032	IV.A.6.b).(1)	<u>Any clinical experiences done to fulfill the prerequisite</u>
1033		<u>clinical experiences in internal medicine described in</u>
1034		<u>Section III.A.4. will not count toward the 12 months of</u>
1035		<u>minimum required clinical experiences in critical care</u>
1036		<u>medicine.</u>
1037		
1038	IV.A.6.c)	<u>Twelve additional months must be devoted to appropriate elective</u>
1039		<u>experiences or scholarly activity.</u>
1040		
1041	IV.A.6.c).(1)	<u>Fellows who have completed a previous two- to three-year</u>
1042		<u>ACGME-accredited internal medicine subspecialty</u>
1043		<u>fellowship will automatically satisfy this requirement.</u>
1044		
1045	IV.A.6.d)	<u>Fellows must participate in training using simulation.</u>
1046		
1047	IV.A.6.e)	Fellows must learn the principles and techniques of administration
1048		and management of a MICU. Fellows must be informed of the
1049		<u>clinical outcomes of their patients who are discharged from the</u>
1050		<u>critical care units.</u>
1051		
1052	IV.A.6.f)	Fellows must have formal instruction and clinical experience in the
1053		evaluation and management of patients:
1054		
1055	IV.A.6.f).(1)	with trauma;
1056		
1057	IV.A.6.f).(2)	with neurosurgical emergencies;
1058		
1059	IV.A.6.f).(3)	with critical obstetric and gynecologic disorders; and,
1060		
1061	IV.A.6.f).(4)	after discharge from the critical care unit.

1062		
1063	IV.A.6.g)	Procedures and Technical Skills
1064		
1065	IV.A.6.g).(1)	<u>Direct supervision of procedures performed by each fellow must occur until proficiency has been acquired and documented by the program director.</u>
1066		
1067		
1068		
1069	IV.A.6.g).(2)	A skilled preceptor <u>Faculty members</u> must be available to teach and supervise the fellows in the performance <u>and interpretation of these procedures.</u> <u>Procedures</u> must be documented in each fellow's record, giving indications, outcomes, diagnoses, and supervisor(s).
1070		
1071		
1072		
1073		
1074		
1075	IV.A.6.g).(3)	<u>It is suggested that fellows have clinical experience in the placement of percutaneous tracheostomies.</u>
1076		
1077		
1078	IV.A.6.g).(4)	The Fellows must have experience <u>be given opportunities to function</u> in the role of an critical care medicine consultant in the inpatient setting.
1079		
1080		
1081		
1082	IV.B.	Fellows' Scholarly Activities
1083		
1084	IV.B.1.	The curriculum must advance fellows' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.
1085		
1086		
1087		
1088	IV.B.2.	Fellows should participate in scholarly activity.
1089		
1090	IV.B.2.a)	The majority of fellows must demonstrate evidence of <u>scholarship</u> recent research productivity <u>conducted during the fellowship through one or more of the following:</u>
1091		
1092		
1093		
1094	IV.B.2.a).(1)	<u>publication of articles, book chapters, abstracts, or case reports in peer-reviewed journals;</u>
1095		
1096		
1097	IV.B.2.a).(2)	<u>publication of peer-reviewed performance improvement or education research;</u>
1098		
1099		
1100	IV.B.2.a).(3)	<u>peer-reviewed funding; or,</u>
1101		
1102	IV.B.2.a).(4)	<u>peer-reviewed abstracts presented at regional, state, or national specialty meetings.</u>
1103		
1104		
1105	IV.B.3.	The sponsoring institution and program should allocate adequate educational resources to facilitate fellow involvement in scholarly activities.
1106		
1107		
1108		
1109	V.	Evaluation
1110		
1111	V.A.	Fellow
1112		

1113	V.A.1.	Formative Evaluation
1114		
1115	V.A.1.a)	The faculty must evaluate fellow performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.
1116		
1117		
1118		
1119		
1120	V.A.1.a).(1)	The faculty must discuss this evaluation with the <u>each</u> fellow at the completion of the <u>each</u> assignment.
1121		
1122		
1123	V.A.1.a).(2)	<u>Assessment of procedural competence should not be based solely on a minimum number of procedures performed, but on a formal evaluation process.</u>
1124		
1125		
1126		
1127	V.A.1.b)	The program must:
1128		
1129	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;
1130		
1131		
1132		
1133		
1134		
1135	V.A.1.b).(1).(a)	<u>Patient Care</u>
1136		
1137		
1138		<u>The program must assess the fellow in data gathering, clinical reasoning, patient management, and procedures in the inpatient setting. This assessment must involve direct observation of fellow-patient encounters.</u>
1139		
1140		
1141		
1142		
1143	V.A.1.b).(1).(a).(i)	Each program must define a standard for <u>proficiency-competence</u> for all required and elective procedures.
1144		
1145		
1146		
1147	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>
1148		
1149		
1150		
1151		
1152		
1153	V.A.1.b).(1).(b)	<u>Medical Knowledge</u>
1154		
1155		<u>The program must use an objective formative assessment method. The same formative assessment method must be administered at least twice during the program.</u>
1156		
1157		
1158		
1159		
1160	V.A.1.b).(1).(c)	<u>Practice-based Learning and Improvement</u>
1161		
1162		<u>The program must use performance data to assess fellow in:</u>
1163		

1164		
1165	V.A.1.b).(1).(c).(i)	<u>application of evidence to patient care;</u>
1166		
1167	V.A.1.b).(1).(c).(ii)	<u>practice improvement;</u>
1168		
1169	V.A.1.b).(1).(c).(iii)	<u>teaching skills involving peers; and,</u>
1170		
1171	V.A.1.b).(1).(c).(iv)	<u>scholarship.</u>
1172		
1173	V.A.1.b).(1).(d)	<u>Interpersonal and Communication Skills</u>
1174		
1175		<u>The program must use both direct observation and</u>
1176		<u>multi-source evaluation, including peers, and non-</u>
1177		<u>physician team members, to assess fellow</u>
1178		<u>performance in:</u>
1179		
1180	V.A.1.b).(1).(d).(i)	<u>communication with patient and family;</u>
1181		
1182	V.A.1.b).(1).(d).(ii)	<u>teamwork;</u>
1183		
1184	V.A.1.b).(1).(d).(iii)	<u>communication with peers, including</u>
1185		<u>transitions in care; and,</u>
1186		
1187	V.A.1.b).(1).(d).(iv)	<u>record keeping.</u>
1188		
1189	V.A.1.b).(1).(e)	<u>Professionalism</u>
1190		
1191		<u>The program must use multi-source evaluation,</u>
1192		<u>including peers, and non-physician team members,</u>
1193		<u>to assess the fellow's:</u>
1194		
1195	V.A.1.b).(1).(e).(i)	<u>honesty and integrity;</u>
1196		
1197	V.A.1.b).(1).(e).(ii)	<u>ability to meet professional responsibilities;</u>
1198		
1199	V.A.1.b).(1).(e).(iii)	<u>ability to maintain appropriate professional</u>
1200		<u>relationships with patients and colleagues;</u>
1201		<u>and,</u>
1202		
1203	V.A.1.b).(1).(e).(iv)	<u>commitment to self-improvement.</u>
1204		
1205	V.A.1.b).(1).(f)	<u>Systems-based Practice</u>
1206		
1207		<u>The program must use multi-source evaluation,</u>
1208		<u>including peers, and non-physician team members,</u>
1209		<u>to assess the fellow's:</u>
1210		
1211	V.A.1.b).(1).(f).(i)	<u>ability to provide care coordination,</u>
1212		<u>including transition of care;</u>
1213		
1214	V.A.1.b).(1).(f).(ii)	<u>ability to work in interdisciplinary teams;</u>

1215		
1216	V.A.1.b).(1).(f).(iii)	<u>advocacy for quality of care; and,</u>
1217		
1218	V.A.1.b).(1).(f).(iv)	<u>ability to identify system problems and</u>
1219		<u>participate in improvement activities.</u>
1220		
1221	V.A.1.b).(2)	use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);
1222		
1223		
1224	V.A.1.b).(3)	document progressive fellow performance
1225		improvement appropriate to educational level; and,
1226		
1227	V.A.1.b).(4)	provide each fellow with documented semiannual
1228		evaluation of performance with feedback.
1229		
1230	V.A.1.c)	The evaluations of fellow performance must be accessible for
1231		review by the fellow, in accordance with institutional policy.
1232		
1233	V.A.2.	Summative Evaluation
1234		
1235		The program director must provide a summative evaluation for each
1236		fellow upon completion of the program. This evaluation must
1237		become part of the fellow's permanent record maintained by the
1238		institution, and must be accessible for review by the fellow in
1239		accordance with institutional policy. This evaluation must:
1240		
1241	V.A.2.a)	document the fellow's performance during the final period of
1242		education; and
1243		
1244	V.A.2.b)	verify that the fellow has demonstrated sufficient competence
1245		to enter practice without direct supervision.
1246		
1247	V.B.	Faculty Evaluation
1248		
1249	V.B.1.	At least annually, the program must evaluate faculty performance as
1250		it relates to the educational program.
1251		
1252	V.B.2.	These evaluations should include a review of faculty's clinical
1253		teaching abilities, commitment to the educational program, clinical
1254		knowledge, professionalism, and scholarly activities.
1255		
1256	V.B.3.	This evaluation must include at least annual written confidential
1257		evaluations by fellows.
1258		
1259	V.B.3.a)	In addition, Fellows must have the opportunity to provide
1260		confidential written evaluations of each supervising faculty
1261		<u>member</u> teaching attending at the end of a <u>each</u> rotation.
1262		
1263	V.B.3.b)	The program director must be reviewed These evaluations <u>must</u>
1264		<u>be reviewed</u> with each attending <u>faculty member</u> annually.

1265		
1266	V.C.	Program Evaluation and Improvement
1267		
1268	V.C.1.	The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:
1269		
1270		
1271		
1272	V.C.1.a)	fellow performance;
1273		
1274	V.C.1.b)	faculty development;
1275		
1276	V.C.1.c)	graduate performance, including performance of program graduates on the certification examination; and,
1277		
1278		
1279	V.C.1.c).(1)	At least 80% of a program's graduating fellows from those eligible to take an ABIM subspecialty certifying examination upon completion of their training for the most recently defined five-year period who are eligible should must have taken an the ABIM subspecialty certifying examination. (Note: Five-year rolling pass rate for first time takers of the ABIM certifying examination will be examined at each program review).
1280		
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1288	V.C.1.c).(2)	<u>At least 80% of a program's graduates taking the ABIM certifying examination for the first time during the most recently defined five-year period should pass.</u>
1289		
1290		
1291		
1292	V.C.1.d)	program quality. Specifically:
1293		
1294	V.C.1.d).(1)	Fellows and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually.
1295		
1296		
1297		
1298	V.C.1.d).(2)	The program must use the results of fellows' assessments of the program together with other program evaluation results to improve the program.
1299		
1300		
1301		
1302	V.C.1.d).(3)	<u>At least 80% of the entering fellows should have completed the program when averaged over a five-year period.</u>
1303		
1304		
1305		
1306	V.C.2.	If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.
1307		
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1311		
1312	V.C.3.	<u>Representative program personnel, at a minimum to include the program director, representative faculty, and one fellow, must review program goals and objectives, and the effectiveness with which they are achieved.</u>
1313		
1314		

- 1315
1316 **VI. Fellow Duty Hours in the Learning and Working Environment**
1317
1318 **VI.A. Professionalism, Personal Responsibility, and Patient Safety**
1319
1320 **VI.A.1. Programs and sponsoring institutions must educate fellows and**
1321 **faculty members concerning the professional responsibilities of**
1322 **physicians to appear for duty appropriately rested and fit to provide**
1323 **the services required by their patients.**
1324
1325 **VI.A.2. The program must be committed to and responsible for promoting**
1326 **patient safety and fellow well-being in a supportive educational**
1327 **environment.**
1328
1329 **VI.A.3. The program director must ensure that fellows are integrated and**
1330 **actively participate in interdisciplinary clinical quality improvement**
1331 **and patient safety programs.**
1332
1333 **VI.A.4. The learning objectives of the program must:**
1334
1335 **VI.A.4.a) be accomplished through an appropriate blend of supervised**
1336 **patient care responsibilities, clinical teaching, and didactic**
1337 **educational events; and,**
1338
1339 **VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill**
1340 **non-physician service obligations.**
1341
1342 **VI.A.4.b).(1) ~~Fellows' service responsibilities must be limited to patients~~**
1343 **~~for whom the teaching service has diagnostic and~~**
1344 **~~therapeutic responsibility.~~**
1345
1346 **VI.A.5. The program director and institution must ensure a culture of**
1347 **professionalism that supports patient safety and personal**
1348 **responsibility. Fellows and faculty members must demonstrate an**
1349 **understanding and acceptance of their personal role in the**
1350 **following:**
1351
1352 **VI.A.5.a) assurance of the safety and welfare of patients entrusted to**
1353 **their care;**
1354
1355 **VI.A.5.b) provision of patient- and family-centered care;**
1356
1357 **VI.A.5.c) assurance of their fitness for duty;**
1358
1359 **VI.A.5.d) management of their time before, during, and after clinical**
1360 **assignments;**
1361
1362 **VI.A.5.e) recognition of impairment, including illness and fatigue, in**
1363 **themselves and in their peers;**
1364

- 1365 VI.A.5.f) attention to lifelong learning;
1366
1367 VI.A.5.g) the monitoring of their patient care performance improvement
1368 indicators; and,
1369
1370 VI.A.5.h) honest and accurate reporting of duty hours, patient
1371 outcomes, and clinical experience data.
1372
1373 VI.A.6. All fellows and faculty members must demonstrate responsiveness
1374 to patient needs that supersedes self-interest. Physicians must
1375 recognize that under certain circumstances, the best interests of the
1376 patient may be served by transitioning that patient's care to another
1377 qualified and rested provider.
1378
1379 VI.B. Transitions of Care
1380
1381 VI.B.1. Programs must design clinical assignments to minimize the number
1382 of transitions in patient care.
1383
1384 VI.B.2. Sponsoring institutions and programs must ensure and monitor
1385 effective, structured hand-over processes to facilitate both
1386 continuity of care and patient safety.
1387
1388 VI.B.3. Programs must ensure that fellows are competent in communicating
1389 with team members in the hand-over process.
1390
1391 VI.B.4. The sponsoring institution must ensure the availability of schedules
1392 that inform all members of the health care team of attending
1393 physicians and fellows currently responsible for each patient's care.
1394
1395 VI.C. Alertness Management/Fatigue Mitigation
1396
1397 VI.C.1. The program must:
1398
1399 VI.C.1.a) educate all faculty members and fellows to recognize the
1400 signs of fatigue and sleep deprivation;
1401
1402 VI.C.1.b) educate all faculty members and fellows in alertness
1403 management and fatigue mitigation processes; and,
1404
1405 VI.C.1.c) adopt fatigue mitigation processes to manage the potential
1406 negative effects of fatigue on patient care and learning, such
1407 as naps or back-up call schedules.
1408
1409 VI.C.2. Each program must have a process to ensure continuity of patient
1410 care in the event that a fellow may be unable to perform his/her
1411 patient care duties.
1412
1413 VI.C.3. The sponsoring institution must provide adequate sleep facilities
1414 and/or safe transportation options for fellows who may be too

1465		modalities, and is available to provide Direct
1466		Supervision.
1467		
1468	VI.D.3.c)	Oversight – the supervising physician is available to provide
1469		review of procedures/encounters with feedback provided
1470		after care is delivered.
1471		
1472	VI.D.4.	The privilege of progressive authority and responsibility, conditional
1473		independence, and a supervisory role in patient care delegated to
1474		each fellow must be assigned by the program director and faculty
1475		members.
1476		
1477	VI.D.4.a)	The program director must evaluate each fellow’s abilities
1478		based on specific criteria. When available, evaluation should
1479		be guided by specific national standards-based criteria.
1480		
1481	VI.D.4.b)	Faculty members functioning as supervising physicians
1482		should delegate portions of care to fellows, based on the
1483		needs of the patient and the skills of the fellows.
1484		
1485	VI.D.4.c)	Senior residents or fellows should serve in a supervisory role
1486		of junior residents in recognition of their progress toward
1487		independence, based on the needs of each patient and the
1488		skills of the individual resident or fellow.
1489		
1490	VI.D.5.	Programs must set guidelines for circumstances and events in
1491		which fellows must communicate with appropriate supervising
1492		faculty members, such as the transfer of a patient to an intensive
1493		care unit, or end-of-life decisions.
1494		
1495	VI.D.5.a)	Each fellow must know the limits of his/her scope of
1496		authority, and the circumstances under which he/she is
1497		permitted to act with conditional independence.
1498		
1499	VI.D.5.a).(1)	In particular, PGY-1 residents should be supervised
1500		either directly or indirectly with direct supervision
1501		immediately available.
1502		
1503	VI.D.6.	Faculty supervision assignments should be of sufficient duration to
1504		assess the knowledge and skills of each fellow and delegate to
1505		him/her the appropriate level of patient care authority and
1506		responsibility.
1507		
1508	VI.E.	Clinical Responsibilities
1509		
1510		The clinical responsibilities for each fellow must be based on PGY-level,
1511		patient safety, fellow education, severity and complexity of patient
1512		illness/condition and available support services.
1513		
1514	VI.F.	Teamwork

1515
1516 **Fellows must care for patients in an environment that maximizes effective**
1517 **communication. This must include the opportunity to work as a member of**
1518 **effective interprofessional teams that are appropriate to the delivery of care**
1519 **in the specialty.**

1520
1521 **VI.G. Fellow Duty Hours**

1522
1523 **VI.G.1. Maximum Hours of Work per Week**

1524
1525 **Duty hours must be limited to 80 hours per week, averaged over a**
1526 **four-week period, inclusive of all in-house call activities and all**
1527 **moonlighting.**

1528
1529 **VI.G.1.a) Duty Hour Exceptions**

1530
1531 **A Review Committee may grant exceptions for up to 10% or a**
1532 **maximum of 88 hours to individual programs based on a**
1533 **sound educational rationale.**

1534
1535 The Review Committee for Internal Medicine will not consider
1536 requests for exceptions to the 80-hour limit to the fellows' work
1537 week.

1538
1539 **VI.G.1.a).(1) In preparing a request for an exception the program**
1540 **director must follow the duty hour exception policy**
1541 **from the ACGME Manual on Policies and Procedures.**

1542
1543 **VI.G.1.a).(2) Prior to submitting the request to the Review**
1544 **Committee, the program director must obtain approval**
1545 **of the institution's GMEC and DIO.**

1546
1547 **VI.G.2. Moonlighting**

1548
1549 **VI.G.2.a) Moonlighting must not interfere with the ability of the fellow**
1550 **to achieve the goals and objectives of the educational**
1551 **program.**

1552
1553 **VI.G.2.b) Time spent by fellows in Internal and External Moonlighting**
1554 **(as defined in the ACGME Glossary of Terms) must be**
1555 **counted towards the 80-hour Maximum Weekly Hour Limit.**

1556
1557 **VI.G.2.c) PGY-1 residents are not permitted to moonlight.**

1558
1559 **VI.G.3. Mandatory Time Free of Duty**

1560
1561 **Fellows must be scheduled for a minimum of one day free of duty**
1562 **every week (when averaged over four weeks). At-home call cannot**
1563 **be assigned on these free days.**

1564

1565	VI.G.4.	Maximum Duty Period Length
1566		
1567	VI.G.4.a)	Duty periods of PGY-1 residents must not exceed 16 hours in duration.
1568		
1569		
1570	VI.G.4.b)	Duty periods of PGY-2 residents and above 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.
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1572		
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1576		
1577		
1578	VI.G.4.b).(1)	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.
1579		
1580		
1581		
1582		
1583		
1584	VI.G.4.b).(2)	Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
1585		
1586		
1587		
1588	VI.G.4.b).(3)	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.
1589		
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1594		
1595		
1596		
1597	VI.G.4.b).(3).(a)	Under those circumstances, the fellow must:
1598		
1599	VI.G.4.b).(3).(a).(i)	appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
1600		
1601		
1602		
1603	VI.G.4.b).(3).(a).(ii)	document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
1604		
1605		
1606		
1607		
1608	VI.G.4.b).(3).(b)	The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.
1609		
1610		
1611		
1612		
1613	VI.G.5.	Minimum Time Off between Scheduled Duty Periods
1614		

- 1615 **VI.G.5.a)** **PGY-1 residents should have 10 hours, and must have eight**
1616 **hours, free of duty between scheduled duty periods.**
1617
- 1618 **VI.G.5.b)** **Intermediate-level residents should have 10 hours free of**
1619 **duty, and must have eight hours between scheduled duty**
1620 **periods. They must have at least 14 hours free of duty after 24**
1621 **hours of in-house duty.**
1622
1623 Internal medicine subspecialty fellows are considered to be in the
1624 final years of education.
1625
- 1626 **VI.G.5.c)** **Residents in the final years of education must be prepared to**
1627 **enter the unsupervised practice of medicine and care for**
1628 **patients over irregular or extended periods.**
1629
- 1630 **VI.G.5.c).(1)** **This preparation must occur within the context of the**
1631 **80-hour, maximum duty period length, and one-day-**
1632 **off-in-seven standards. While it is desirable that**
1633 **fellows in their final years of education have eight**
1634 **hours free of duty between scheduled duty periods,**
1635 **there may be circumstances when these fellows must**
1636 **stay on duty to care for their patients or return to the**
1637 **hospital with fewer than eight hours free of duty.**
1638
- 1639 **VI.G.5.c).(1).(a)** **Circumstances of return-to-hospital activities**
1640 **with fewer than eight hours away from the**
1641 **hospital by fellows in their final years of**
1642 **education must be monitored by the program**
1643 **director.**
1644
- 1645 **VI.G.5.c).(1).(b)** In unusual circumstances, fellows may remain
1646 beyond their scheduled period of duty or return
1647 after their scheduled period of duty to provide care
1648 to a single patient. Justifications for such
1649 extensions of duty are limited to reasons of
1650 required continuity of care for a severely ill or
1651 unstable patient, academic importance of the
1652 events transpiring, or humanistic attention to the
1653 needs of the patient or family. Such episodes
1654 should be rare, must be of the fellows' own
1655 initiative, and need not initiate a new 'off-duty
1656 period' nor require a change in the scheduled 'off-
1657 duty period.'
1658
- 1659 **VI.G.5.c).(1).(c)** Under such circumstances, the fellow must
1660 appropriately hand over care of all other patients to
1661 the team responsible for their continuing care, and
1662 document the reasons for remaining or returning to
1663 care for the patient in question and submit that
1664 documentation to the program director.

1665
1666 VI.G.5.c).(1).(d) The program director must review each submission
1667 of additional service and track both individual
1668 fellows' and program-wide episodes of additional
1669 duty.
1670

1671 **VI.G.6. Maximum Frequency of In-House Night Float**
1672
1673 **Fellows must not be scheduled for more than six consecutive nights**
1674 **of night float.**
1675

1676 **VI.G.7. Maximum In-House On-Call Frequency**
1677
1678 **PGY-2 residents and above must be scheduled for in-house call no**
1679 **more frequently than every-third-night (when averaged over a four-**
1680 **week period).**
1681

1682 VI.G.7.a) ~~Internal medicine residency programs are fellowships~~ must not
1683 allowed to average in-house call over a four-week period.
1684

1685 **VI.G.8. At-Home Call**
1686

1687 **VI.G.8.a) Time spent in the hospital by fellows on at-home call must**
1688 **count towards the 80-hour maximum weekly hour limit. The**
1689 **frequency of at-home call is not subject to the every-third-**
1690 **night limitation, but must satisfy the requirement for one-day-**
1691 **in-seven free of duty, when averaged over four weeks.**
1692

1693 **VI.G.8.a).(1) At-home call must not be so frequent or taxing as to**
1694 **preclude rest or reasonable personal time for each**
1695 **fellow.**
1696

1697 **VI.G.8.b) Fellows are permitted to return to the hospital while on at-**
1698 **home call to care for new or established patients. Each**
1699 **episode of this type of care, while it must be included in the**
1700 **80-hour weekly maximum, will not initiate a new "off-duty**
1701 **period".**
1702

1703 **VII. Innovative Projects**
1704

1705 **Requests for innovative projects that may deviate from the institutional, common**
1706 **and/or specialty specific program requirements must be approved in advance by**
1707 **the Review Committee. In preparing requests, the program director must follow**
1708 **Procedures for Approving Proposals for Innovative Projects located in the ACGME**
1709 **Manual on Policies and Procedures. Once a Review Committee approves a**
1710 **project, the sponsoring institution and program are jointly responsible for the**
1711 **quality of education offered to fellows for the duration of such a project.**
1712

1713 ***
1714

1715 ACGME-approved: October 1, 2011; Effective: July 1, 2012