ACGME Program Requirements for Graduate Medical Education in Allergy and Immunology

Common Program Requirements are in BOLD

Effective: ~~July 1, 2007~~

Introduction

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

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

~~Int.B.~~ ~~Definition and Scope of the Specialty~~

Int.B.~~1.~~ ~~Graduate medical education programs in allergy and immunology should prepare~~ Allergy and immunology specialists ~~to~~ provide expert medical care for patients with allergic and immunologic disorders. These specialists may serve as consultants, educators, and physician scientists in asthma, allergic disorders, immunologic disorders, and immunodeficiency diseases.

~~Int.B.2.~~ ~~Residents in this specialty have specific competencies in the care of patients of all ages.~~

~~Int.C.~~ ~~Duration and Scope of Education~~

Int.C.~~1.~~ The ~~length of the~~ educational program in allergy and immunology must be ~~is~~ 24 months in length ~~of full-time education. The Review Committee recognizes that this may be accomplished in two ways: 24 consecutive months of education, or over 36 months that includes a total of 24 months of allergy and immunology education~~.

~~Int.C.2.~~ ~~Residents must demonstrate competencies in treating children and adults with asthma, allergic disorders, immunologic disorders, and immunodeficiency diseases.~~

~~Int.C.3.~~ ~~Residents must satisfy the requirements for program completion with 24 months of education. The Review Committee recognizes this may be accomplished in two ways: 24 consecutive months of education, or time spread out over 36 months that includes a total of 24 months of allergy and immunology education. The program must meet the requirements outlined in section IV.~~

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites.

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

I.A.1. ~~Allergy and immunology programs should be conducted principally in institutions with ACGME-accredited graduate medical education programs in both pediatrics and internal medicine. Programs may be based in institutions with ACGME-accredited internal medicine or pediatrics training programs that collaborate with participating institutions that have accredited GME programs in other relevant specialties.~~

I.A.2. ~~The sponsoring institution must ensure sufficient faculty, financial resources, clinical resources, research opportunities, and library facilities to meet the residents' educational needs and to enable the program to comply with accreditation requirements.~~

I.B. Participating Sites

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

The PLA should:

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

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

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

I.B.1.d) **state the policies and procedures that will govern resident education during the assignment.**

I.B.1.e) ~~outline the educational goals and objectives to be attained by the resident during the assignment.~~

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

I.B.3. ~~Assignments at participating sites must be of sufficient length to ensure a quality educational experience and should provide sufficient opportunity for continuity of care. All participating institutions must demonstrate the ability to promote the program goals and educational and peer activities. Exceptions must be justified and approved in advance.~~

I.B.4. Resident education at a ~~private practitioner's office~~ participating site that is a private practitioner's office must be limited to those offices of program faculty members and must have defined goals and objectives.

I.B.4.a) ~~must emphasize that the resident is gaining an educational experience, not providing service to the office. The goals, objectives and manner of supervision must be documented;~~

I.B.4.b) ~~should be one that cannot be met in any other participating institution; and,~~

I.B.4.c) ~~requires that the participating private office practitioner be listed on the Program Information Form (PIF) as a member of the faculty.~~

II. Program Personnel and Resources

II.A. Program Director

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

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

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

II.A.3.a) **requisite specialty expertise and documented educational**

and administrative experience acceptable to the Review Committee;

II.A.3.b) **current certification in the specialty by the American Board of** Allergy and Immunology**, or specialty qualifications that are acceptable to the Review Committee;**

II.A.3.c) **current medical licensure and appropriate medical staff appointment;**

II.A.3.c).(1) Physician faculty members must have a valid unrestricted license to practice medicine in the ~~state~~ jurisdiction where the program's institutional sponsor is located. ~~Program directors in certain federal programs are exempted from the requirement to be licensed in the sponsoring institution's state.~~

II.A.3.d) at least three years' ~~of~~ participation as a~~n active~~ faculty member in an ACGME-accredited allergy and immunology program or possess qualifications acceptable to the Review Committee; and,

II.A.3.e) leadership qualities and sufficient time and effort devoted to the program to provide day-to-day continuity of leadership and to fulfill ~~all of~~ the responsibilities of meeting the educational goals of the program~~; and,~~.

II.A.4. **The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:**

II.A.4.a) **oversee and ensure the quality of didactic and clinical education in all institutions that participate in the program;**

II.A.4.b) **approve a local director at each participating site who is accountable for resident education;**

II.A.4.c) **approve the selection of program faculty as appropriate;**

II.A.4.d) **evaluate program faculty and approve the continued participation of program faculty based on evaluation;**

II.A.4.e) **monitor resident supervision at all participating sites;**

II.A.4.f) **prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;**

II.A.4.g) **provide each resident with documented semiannual evaluation of performance with feedback;**

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206 **II.A.4.h)** **ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;**
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210 **II.A.4.i)** **provide verification of residency education for all residents, including those who leave the program prior to completion;**
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213 **II.A.4.j)** **implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:**
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218 **II.A.4.j).(1)** **distribute these policies and procedures to the residents and faculty;**
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221 **II.A.4.j).(2)** **monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;**
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225 **II.A.4.j).(3)** **adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,**
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228 **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.**
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232 **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;**
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236 **II.A.4.l)** **comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;**
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241 **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;**
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245 **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:**
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249 **II.A.4.n).(1)** **all applications for ACGME accreditation of new programs;**
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252 **II.A.4.n).(2)** **changes in resident complement;**
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254 **II.A.4.n).(3)** **major changes in program structure or length of training;**
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II.A.4.n).(4) **progress reports requested by the RC;**

II.A.4.n).(5) **responses to all proposed adverse actions;**

II.A.4.n).(6) **requests for increases or any change to resident duty hours;**

II.A.4.n).(7) **voluntary withdrawals of ACGME-accredited programs;**

II.A.4.n).(8) **requests for appeal of an adverse action;**

II.A.4.n).(9) **appeal presentations to a Board of Appeal or the ACGME; and,**

II.A.4.n).(10) **proposals to ACGME for approval of innovative educational approaches.**

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:**

II.A.4.o).(1) **program citations, and/or**

II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.**

II.A.4.p) ~~be responsible for ongoing communications with the American Board of Allergy and Immunology. This includes completing interim and final evaluations;~~

II.A.4.q) ~~If an extension of more than three months in the educational program is necessary, the program director must notify the Review Committee of the extension.~~

II.A.4.q).(1) ~~The program director must describe the proposed curriculum for that resident and the measures taken to minimize the impact on other residents. Any changes in rotation schedules should be included in the notification.~~

II.A.4.q).(2) ~~Express permission must be obtained in advance from the Review Committee if the extension is greater than three months.~~

II.B. **Faculty**

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

II.B.1.a) Each program must have at least two ~~key clinical~~ core faculty members.

II.B.1.a).(1) ~~Key~~ Core faculty members must be certified by the American Board of Allergy and Immunology or possess qualifications acceptable to the Review Committee. These faculty members must devote ~~a minimum of 10% effort~~ at least 15 hours per week to ~~A/I~~allergy and immunology resident education ~~training,~~ ~~and can include the Program Director.~~

II.B.1.a).(2) At least one ~~key~~ core faculty member must be a qualified allergist and immunologist who has completed an ACGME- or Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited residency in pediatrics.

II.B.1.a).(3) At least one ~~key~~ core faculty member must be a qualified allergist and immunologist who has completed an ACGME- or Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited residency in internal medicine.

The faculty must:

II.B.1.b) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and

II.B.1.c) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.

II.B.2. The physician faculty must have current certification in the specialty by the American Board of Allergy and Immunology**, or possess qualifications acceptable to the Review Committee.**

II.B.2.a) ~~The faculty must include:~~

II.B.2.b) ~~qualified allergist(s) and immunologist(s) having residency training in internal medicine~~, ~~and who are assigned to a participating site;~~

II.B.2.c) ~~qualified allergist(s) and immunologist(s) having residency training in pediatrics,~~ ~~and who are assigned to a participating site;~~

II.B.2.c).(1) ~~a faculty member who is residency trained in both internal medicine and pediatrics may fulfill the requirements in either Section II.B.2.a or II.B.2.b.~~

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

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

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

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

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

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

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

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

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

II.B.5.c) **Faculty should encourage and support residents in scholarly activities.**

II.B.6. ~~All regularly participating faculty must be included in the PIF, with delineation of the number of hours spent in the education program.~~

II.B.7. ~~The~~ Physician faculty members must demonstrate competence in both clinical care and teaching abilities.

II.B.8. Physician faculty members who are not specialists in allergy and immunology must be certified in their specialties by the appropriate American Board of Medical Specialties (ABMS) board or the RCPSC, ~~in their specialty or have equivalent qualifications.~~ or possess qualifications that are acceptable to the Review Committee.

II.B.9. ~~The faculty must actively pursue scholarly activity in allergy and immunology and encourage residents to engage in scholarly activity.~~

II.C. **Other Program Personnel**

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

II.C.1. All other program personnel ~~faculty~~, ~~such as~~ including health care providers and scientists, must be appropriately qualified in their area of

expertise.

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.

II.D.1. The program must provide a sufficient number of pediatric and adult patients to provide education in asthma, allergic disorders, immunologic disorders, and immunodeficiency diseases.

II.D.2. A sufficient number of adult and pediatric ~~ambulatory~~ patients must be provided for each resident during the 24-month program.

II.E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

III. Resident Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.

III.A.1. Prior to appointment in the program, residents must ~~Residents admitted to allergy and immunology programs~~ have successfully completed ~~a program in~~ an internal medicine or pediatrics residency program accredited by the ~~Accreditation Council for Graduate Medical Education (~~ACGME~~)~~ or the RCPSC.

III.A.2. ~~Before entry into~~ Prior to appointment in the program, each resident must be notified in writing of the required length of the ~~allergy and immunology educational~~ program.

III.B. Number of Residents

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

III.B.1. ~~The Review Committee for Allergy and Immunology does not approve a specific number of resident positions. At the time of program review, the Committee will judge the adequacy of the program's resources to support the number of resident positions proposed.~~

III.C. Resident Transfers

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

III.C.1.a) ~~Resident transfers must be reported to the Review Committee and the American Board of Allergy and Immunology. The transfer document should include an assessment of competencies in the six areas described in Section IV.5.~~

III.C.2. **A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.**

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

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

IV. Educational Program

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

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

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

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

IV.A.3.a) ~~attendance at~~ Didactic sessions must include regularly scheduled conferences, lectures, journal clubs, or seminars. ~~; and, reading and preparation for teaching assignments;~~

IV.A.3.a).(1) Residents must attend at least 70% of required didactic sessions.

IV.A.3.b) Required core didactic topics must include: ~~must study~~ ~~asthma, allergic disorders, immunologic disorders, and immunodeficiency diseases. must have a structured curriculum in~~

511 IV.A.3.b).(1) pathophysiology, diagnosis, differential diagnosis,
512 complications, and treatment of the following diseases and
513 circumstances:
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515 IV.A.3.b).(1).(a) anaphylaxis, asthma, atopic dermatitis, contact
516 dermatitis, drug allergy, food allergy, rhinitis and
517 nasal polyps, sinusitis, stinging insect sensitivity,
518 ocular allergy, acute and chronic
519 urticaria/angioedema, and hereditary and acquired
520 angioedema;
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522 IV.A.3.b).(1).(b) primary immunodeficiency, to include humoral
523 defects, cellular defects, phagocytic defects,
524 complement defects, and other genetic defects;
525
526 IV.A.3.b).(1).(c) acquired immunodeficiency, to include: malignancy,
527 infectious causes, and nutritional/metabolic causes;
528 and,
529
530 IV.A.3.b).(1).(d) autoimmune diseases, allergic bronchopulmonary
531 aspergillosis, eosinophilic disorders,
532 hypersensitivity pneumonitis, mastocytosis,
533 occupational lung disease, vasculitis,
534 autoinflammatory disorders ~~(e.g., Familial~~
535 ~~Mediterranean Fever, TRAPS, Hyper-IgD)~~, and
536 cystic fibrosis.
537
538 IV.A.3.b).(2) basic science knowledge and principles related to
539 diagnostic testing and treatment modalities, including:
540
541 IV.A.3.b).(2).(a) ~~allergens~~ aerobiology, to include identification of
542 relevant allergens;
543
544 IV.A.3.b).(2).(b) allergen measurement and environmental controls;
545
546 IV.A.3.b).(2).(c) allergen extracts, to include preparation,
547 standardization, prescription writing, and
548 administration;
549
550 IV.A.3.b).(2).(d) pharmacology, to include mechanisms of action,
551 pharmacokinetics, drug development, drug
552 metabolism, drug interactions, drug side effects,
553 and preparation and use of monoclonal antibodies;
554
555 IV.A.3.b).(2).(e) diagnostic testing of allergic diseases, to include
556 sensitivity and specificity, cost, immediate
557 hypersensitivity skin testing, patch testing, in vitro
558 testing, and specialty laboratory testing;
559
560 IV.A.3.b).(2).(f) special types of skin testing ~~(e.g.,~~ to include
561 physical urticaria~~,~~ and autologous skin tests~~)~~;

562
563 IV.A.3.b).(2).(g) nasal cytology, rhinoscopy, skin biopsies, and food
564 challenge testing;
565
566 IV.A.3.b).(2).(h) ~~other necessary components of the curriculum,~~
567 pulmonary physiology and ~~testing~~ pulmonary
568 function testing, ~~including~~ to include methods and
569 reliability, and provocation challenges for bronchial
570 reactivity;
571
572 IV.A.3.b).(2).(i) diagnostic testing, ~~of clinical immunology diseases~~
573 ~~that include~~ to include:
574
575 IV.A.3.b).(2).(i).(i) principles and techniques of clinical
576 immunology laboratory procedures;
577
578 IV.A.3.b).(2).(i).(ii) tests for humoral immunity, ~~tests for~~ cellular
579 immunity, neutrophil function, cytokines,
580 immune complexes, cryoprecipitable
581 proteins, total serum complement activity
582 and individual components,
583 histocompatibility, ~~tests for~~ acquired
584 immunodeficiencies, ~~tests for~~ autoimmunity
585 and vasculitis; and,
586
587 IV.A.3.b).(2).(i).(iii) preparation and use of monoclonal
588 antibodies~~;~~.
589
590 IV.A.3.b).(2).(j) intravenous immunoglobulins, to include
591 mechanism of action, pharmacological properties,
592 administration, development, contraindications and
593 side effects, and cost; and,
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595 IV.A.3.b).(2).(k) vaccines and immunotherapies, to include
596 mechanism of action, administration, development,
597 contraindications and side effects, tests for vaccine
598 response, and use in immunodeficiencies.
599
600 IV.A.3.b).(3) ~~other~~ basic science and other areas important to clinical
601 practice, including:
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603 IV.A.3.b).(3).(a) immunology, to include transplantation,
604 gastrointestinal, skin, reproductive, endocrine,
605 tumor, and molecular/immunobiology;
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607 IV.A.3.b).(3).(b) diagnostic imaging;
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609 IV.A.3.b).(3).(c) mechanisms of inflammation;
610
611 IV.A.3.b).(3).(d) ~~knowledge of~~ controversial or unproven drug or
612 therapeutic techniques in allergy asthma allergic

disorders, immunologic disorders, and immunodeficiency diseases;

IV.A.3.b).(3).(e) ethics, to include ~~acquire a working knowledge of~~ research ethics and principles of confidentiality;

IV.A.3.b).(3).(f) psychological effects of chronic illness;

IV.A.3.b).(3).(g) practice management insurance, coding, billing, patient satisfaction, malpractice, healthcare politics; and,

IV.A.3.b).(3).(h) costs of therapy and diagnostic testing.

IV.A.4. **Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,**

IV.A.5. **ACGME Competencies**

The program must integrate the following ACGME competencies into the curriculum:

IV.A.5.a) **Patient Care**

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

IV.A.5.a).(1) must demonstrate proficiency in: ~~the following allergy and immunology specific competencies to begin the independent practice of this specialty;~~

IV.A.5.a).(1).(a) ~~must conduct~~ conducting comprehensive and detailed medical interviews with children and adults who present suspected allergic and/or immunologic disorders;

IV.A.5.a).(1).(b) ~~must perform~~ performing a physical examination appropriate to the specialty;

IV.A.5.a).(1).(c) ~~must select, perform, and interpret~~ selecting, performing, and interpreting the results of diagnostic tests and studies; and,

IV.A.5.a).(1).(d) ~~must assess~~ assessing the risks and benefits of allergic and immunologic disorder therapies, including ~~(e.g.,~~ drug therapy, allergen immunotherapy, immunomodulatory therapy~~);~~.

IV.A.5.a).(2) ~~must counsel and educate patients about diagnosis,~~

664 ~~prognosis, and treatment;~~
665
666 IV.A.5.a).(3) ~~must consult with and educate other physicians and health~~
667 ~~care providers;~~
668
669 IV.A.5.a).(4) ~~must apply basic and clinical science to the clinical care of~~
670 ~~patients~~;
671
672 IV.A.5.a).(5) ~~must coordinate including the use of consultation;~~
673
674 IV.A.5.a).(6) ~~must analyze medical and other scientific literature~~;
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676 IV.A.5.a).(7) ~~ensure that residents have formal instruction and, clinical~~
677 ~~experience with, as well as~~ must demonstrate proficiency
678 in performing and evaluating, to the satisfaction of the
679 program director or designated faculty member, and at
680 least five times per procedure, results for each of the
681 following: ~~These procedures must be entered into the~~
682 ~~ACGME Resident Case Log System: These procedures~~
683 ~~are required by the American Board of Allergy and~~
684 ~~Immunology for certification.~~
685
686 IV.A.5.a).(7).(a) allergen immunotherapy;
687
688 IV.A.5.a).(7).(b) drug ~~desensitization and challenge~~ hypersensitivity
689 diagnosis and treatment;
690
691 IV.A.5.a).(7).(c) immediate hypersensitivity skin testing;
692
693 IV.A.5.a).(7).(d) immunoglobulin treatment and/or other
694 immunomodulator therapies;
695
696 IV.A.5.a).(7).(e) ~~IVIG treatment and administration~~
697
698 IV.A.5.a).(7).(f) pulmonary function tests~~s~~ ing;
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700 IV.A.5.a).(7).(g) ~~Physical urticaria testing~~
701
702 IV.A.5.a).(7).(h) food ~~challenge testing~~ hypersensitivity diagnosis
703 and treatment; and,
704
705 IV.A.5.a).(8) ~~ensure that residents have proficiency with the following~~
706 ~~procedures~~:
707
708 IV.A.5.a).(8).(a) contact or delayed hypersensitivity ~~skin~~ testing.
709
710 IV.A.5.a).(8).(b) ~~Provocation testing for hyper-reactive airways~~
711
712 IV.A.5.a).(8).(c) ~~Nasal cytology~~
713
714 IV.A.5.a).(8).(d) ~~Patch testing~~

716 IV.A.5.a).(8).(e) ~~Rhinolaryngoscopy~~

718 IV.A.5.a).(9) must enter all required procedures into the ACGME
719 Resident Case Log System.

721 **IV.A.5.b) Medical Knowledge**

723 **Residents must demonstrate knowledge of established and**
724 **evolving biomedical, clinical, epidemiological and social-**
725 **behavioral sciences, as well as the application of this**
726 **knowledge to patient care. Residents:**

728 IV.A.5.b).(1) must demonstrate proficiency in their knowledge of all
729 required core didactic topics through performance in
730 objective examinations and application to patient care.

732 **IV.A.5.c) Practice-based Learning and Improvement**

734 **Residents must demonstrate the ability to investigate and**
735 **evaluate their care of patients, to appraise and assimilate**
736 **scientific evidence, and to continuously improve patient care**
737 **based on constant self-evaluation and life-long learning.**
738 **Residents are expected to develop skills and habits to be able**
739 **to meet the following goals:**

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

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

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

748 **IV.A.5.c).(4) systematically analyze practice using quality**
749 **improvement methods, and implement changes with**
750 **the goal of practice improvement;**

752 **IV.A.5.c).(5) incorporate formative evaluation feedback into daily**
753 **practice;**

755 **IV.A.5.c).(6) locate, appraise, and assimilate evidence from**
756 **scientific studies related to their patients' health**
757 **problems;**

759 IV.A.5.c).(6).(a) Each resident must conduct a comprehensive
760 literature search.

762 **IV.A.5.c).(7) use information technology to optimize learning; and,**

764 **IV.A.5.c).(8) participate in the education of patients, families,**
765 **students, residents and other health professionals.**

IV.A.5.c).(9) ~~apply the principles of data collection, data analysis, and data interpretation;~~

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

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

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

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

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

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

IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable; and,

IV.A.5.d).(6) ~~must~~ counsel and educate patients about diagnosis, prognosis, and treatment.

IV.A.5.e) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

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

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

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

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

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

IV.A.5.f) Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

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

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

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

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

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

IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions.

IV.A.6. Curriculum Organization and Resident Experiences

IV.A.6.a) The program format ~~should~~ must be as follows:

IV.A.6.a).(1) 50% of the program (12-month equivalent) must be devoted to direct patient care activities, including inpatient and outpatient care, clinical case conferences, and record reviews;

IV.A.6.a).(1).(a) ~~must have at~~ At least 20% of the required minimum twelve-month equivalent direct patient care activity must ~~in cross-training experience, including continuity of care in the inpatient and outpatient settings~~ focus on patients from birth to 18 years, including continuity of care in inpatient and outpatient settings.

IV.A.6.a).(1).(b) At least 20% of the required minimum twelve-month equivalent direct patient care activity must focus on patients over the age of 18 years, including continuity of care in inpatient and outpatient settings.

IV.A.6.a).(2) 25% of the program must be devoted to scholarly activities and research; and,

IV.A.6.a).(3) 25% of the program must be devoted to other educational activities.

IV.A.6.a).(3).(a) ~~The “other” category is designed to encourage innovative educational experiences for residents within the program.~~

IV.A.6.a).(3).(b) ~~Examples of “other” include, but are not limited to, the following:~~

IV.A.6.a).(3).(b).(i) ~~residents attendance at conferences and meetings, including national meetings;~~

IV.A.6.a).(3).(b).(ii) ~~educationally valuable committee work within the hospital or with other health organizations;~~

IV.A.6.a).(3).(b).(iii) ~~educationally valuable time devoted to hospital administrative requirements; and,~~

~~time spent fulfilling requirements such as Basic Life Support~~

IV.A.6.b) ~~All residents must be provided with opportunities to apply immunologic theories, principles, and techniques to the investigation, diagnosis, and treatment of a broad spectrum of allergic and immunologic diseases. The clinical education program requires supervised patient care~~; ~~rotations through cooperating services;~~

IV.A.6.b).(1) ~~must devote 50% (12-month equivalent) of their time to direct patient care activities.~~

IV.A.6.c) Resident experiences in direct patient care must include:

IV.A.6.c).(1) ~~must receive cross-training in internal medicine and pediatrics, and pediatric and adult allergy and immunology because specialists in allergy and immunology, whatever their primary specialties, are called on to diagnose and treat individuals of all ages;~~

IV.A.6.c).(2) ~~training in pediatric and adult allergy and immunology and~~

IV.A.6.c).(3) ~~must provide~~ continuing care of pediatric and adult patients with asthma, allergic disorders, immunologic disorders, and immunodeficiency diseases; and,

IV.A.6.c).(3).(a) Each resident must enter these patients into the

919 ACGME Resident Case Log System;
920
921 IV.A.6.c).(4) ~~must have~~ direct patient contact with pediatric ~~children~~ and
922 adult~~s~~ patients with the following diagnoses:
923
924 IV.A.6.c).(4).(a) anaphylaxis;
925
926 IV.A.6.c).(4).(b) asthma;
927
928 IV.A.6.c).(4).(c) atopic dermatitis;
929
930 IV.A.6.c).(4).(d) contact dermatitis;
931
932 IV.A.6.c).(4).(e) drug, vaccine, or immunomodulator allergy, or
933 adverse drug reaction allergy to drugs and other
934 biological agents;
935
936 IV.A.6.c).(4).(f) food allergy;
937
938 IV.A.6.c).(4).(g) primary and acquired immunodeficiency;
939
940 IV.A.6.c).(4).(h) ocular allergies;
941
942 IV.A.6.c).(4).(i) rhinitis;
943
944 IV.A.6.c).(4).(j) sinusitis;
945
946 IV.A.6.c).(4).(k) stinging insect allergy; and,
947
948 IV.A.6.c).(4).(l) urticaria and angioedema.
949
950 IV.A.6.d) ~~are strongly encouraged to have direct contact with, or case~~
951 ~~conference discussions concerning, patients with the following~~
952 ~~diagnoses:~~
953
954 IV.A.6.d).(1) ~~autoimmune disease~~
955
956 IV.A.6.d).(2) ~~allergic bronchopulmonary aspergillosis~~
957
958 IV.A.6.d).(3) ~~eosinophilic disorders~~
959
960 IV.A.6.d).(4) ~~hypersensitivity pneumonitis~~
961
962 IV.A.6.d).(5) ~~vaccine reactions~~
963
964 IV.A.6.d).(6) ~~mastocytosis~~
965
966 IV.A.6.d).(7) ~~occupational lung disease~~
967
968 IV.A.6.d).(8) ~~vasculitis~~
969

IV.B. Residents' Scholarly Activities

IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.;

IV.B.1.a) The program must provide residents with a ~~structured~~ research experience ~~sufficient to result~~ that results in an understanding of the basic principles of study design, performance (including data collection), data analysis (including statistics and epidemiology), and reporting research results.

IV.B.1.b) ~~attain a working knowledge of research design, statistics, clinical trials, epidemiology, and laboratory research;~~

IV.B.1.c) ~~apply the principles of data collection, data analysis, and data interpretation~~

IV.B.2. Residents should participate in scholarly activity.

IV.B.2.a) ~~The program must provide residents with a structured research experience sufficient to result in an understanding of the basic principles of study design, performance, analysis, and reporting.~~

IV.B.2.b) Under faculty supervision, each resident must design~~,~~ and conduct~~, write, and present~~ allergy and/or immunology research in either laboratory-based, epidemiologic, continuous quality improvement, or clinical investigation.

IV.B.2.b).(1) Residents must ~~communicate~~ present their research findings orally and in writing.

IV.B.2.c) ~~design, write, review, or edit research protocols or plans~~

IV.B.2.d) ~~have appropriate supervision for their research activity; and~~

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

V. Evaluation

V.A. Resident Evaluation

V.A.1. Formative Evaluation

V.A.1.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

V.A.1.b) **The program must:**

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;**

V.A.1.b).(2) **use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);**

V.A.1.b).(3) **document progressive resident performance improvement appropriate to educational level; and,**

V.A.1.b).(4) **provide each resident with documented semiannual evaluation of performance with feedback.**

V.A.1.b).(5) ~~use structured checklists and evaluation forms, as encouraged by the Review Committee. The direct observation of resident interactions with patients should be included. Innovation in resident evaluation is encouraged.~~

V.A.1.c) **The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.**

V.A.1.d) ~~Innovation in resident evaluation is encouraged.~~

V.A.2. **Summative Evaluation**

V.A.2.a) **The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:**

V.A.2.b) **document the resident's performance during the final period of education, and**

V.A.2.c) **verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.**

V.B. **Faculty Evaluation**

V.B.1. **At least annually, the program must evaluate faculty performance as it relates to the educational program.**

V.B.2. **These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.**

V.B.3. **This evaluation must include at least annual written confidential evaluations by the residents.**

V.C. Program Evaluation and Improvement

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:**

V.C.1.a) **resident performance;**

V.C.1.b) **faculty development;**

V.C.1.c) **graduate performance, including performance of program graduates on the certification examination; and,**

V.C.1.d) **program quality. Specifically:**

V.C.1.d).(1) **Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and**

V.C.1.d).(2) **The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.**

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.**

V.C.3. ~~One outcome measure of the quality of a residency program is the performance of its graduates on the certifying examinations of the American Board of Allergy and Immunology. In its evaluation of residency programs, the Review Committee will take into consideration the information provided by the American Board of Allergy and Immunology regarding resident performance on the certifying examinations. A program will be judged deficient if a program's pass rate is significantly below the national average over a five-year period~~ At least 70% of the program's graduates from the preceding five years who take the American Board of Allergy and Immunology certifying examination for allergy and immunology for the first time must pass.

VI. Resident Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety

VI.A.1. **Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of**

1123 **physicians to appear for duty appropriately rested and fit to provide**
1124 **the services required by their patients.**
1125
1126 **VI.A.2.** **The program must be committed to and responsible for promoting**
1127 **patient safety and resident well-being in a supportive educational**
1128 **environment.**
1129
1130 **VI.A.3.** **The program director must ensure that residents are integrated and**
1131 **actively participate in interdisciplinary clinical quality improvement**
1132 **and patient safety programs.**
1133
1134 **VI.A.4.** **The learning objectives of the program must:**
1135
1136 **VI.A.4.a)** **be accomplished through an appropriate blend of supervised**
1137 **patient care responsibilities, clinical teaching, and didactic**
1138 **educational events; and,**
1139
1140 **VI.A.4.b)** **not be compromised by excessive reliance on residents to**
1141 **fulfill non-physician service obligations.**
1142
1143 **VI.A.5.** **The program director and institution must ensure a culture of**
1144 **professionalism that supports patient safety and personal**
1145 **responsibility. Residents and faculty members must demonstrate an**
1146 **understanding and acceptance of their personal role in the**
1147 **following:**
1148
1149 **VI.A.5.a)** **assurance of the safety and welfare of patients entrusted to**
1150 **their care;**
1151
1152 **VI.A.5.b)** **provision of patient- and family-centered care;**
1153
1154 **VI.A.5.c)** **assurance of their fitness for duty;**
1155
1156 **VI.A.5.d)** **management of their time before, during, and after clinical**
1157 **assignments;**
1158
1159 **VI.A.5.e)** **recognition of impairment, including illness and fatigue, in**
1160 **themselves and in their peers;**
1161
1162 **VI.A.5.f)** **attention to lifelong learning;**
1163
1164 **VI.A.5.g)** **the monitoring of their patient care performance improvement**
1165 **indicators; and,**
1166
1167 **VI.A.5.h)** **honest and accurate reporting of duty hours, patient**
1168 **outcomes, and clinical experience data.**
1169
1170 **VI.A.6.** **All residents and faculty members must demonstrate**
1171 **responsiveness to patient needs that supersedes self-interest.**
1172 **Physicians must recognize that under certain circumstances, the**
1173 **best interests of the patient may be served by transitioning that**

1174 **patient's care to another qualified and rested provider.**
1175
1176 **VI.B. Transitions of Care**
1177
1178 **VI.B.1. Programs must design clinical assignments to minimize the number**
1179 **of transitions in patient care.**
1180
1181 **VI.B.2. Sponsoring institutions and programs must ensure and monitor**
1182 **effective, structured hand-over processes to facilitate both**
1183 **continuity of care and patient safety.**
1184
1185 **VI.B.3. Programs must ensure that residents are competent in**
1186 **communicating with team members in the hand-over process.**
1187
1188 **VI.B.4. The sponsoring institution must ensure the availability of schedules**
1189 **that inform all members of the health care team of attending**
1190 **physicians and residents currently responsible for each patient's**
1191 **care.**
1192
1193 **VI.C. Alertness Management/Fatigue Mitigation**
1194
1195 **VI.C.1. The program must:**
1196
1197 **VI.C.1.a) educate all faculty members and residents to recognize the**
1198 **signs of fatigue and sleep deprivation;**
1199
1200 **VI.C.1.b) educate all faculty members and residents in alertness**
1201 **management and fatigue mitigation processes; and,**
1202
1203 **VI.C.1.c) adopt fatigue mitigation processes to manage the potential**
1204 **negative effects of fatigue on patient care and learning, such**
1205 **as naps or back-up call schedules.**
1206
1207 **VI.C.2. Each program must have a process to ensure continuity of patient**
1208 **care in the event that a resident may be unable to perform his/her**
1209 **patient care duties.**
1210
1211 **VI.C.3. The sponsoring institution must provide adequate sleep facilities**
1212 **and/or safe transportation options for residents who may be too**
1213 **fatigued to safely return home.**
1214
1215 **VI.D. Supervision of Residents**
1216
1217 **VI.D.1. In the clinical learning environment, each patient must have an**
1218 **identifiable, appropriately-credentialed and privileged attending**
1219 **physician (or licensed independent practitioner as approved by each**
1220 **Review Committee) who is ultimately responsible for that patient's**
1221 **care.**
1222
1223 **VI.D.1.a) This information should be available to residents, faculty**
1224 **members, and patients.**

1225
1226 **VI.D.1.b)** **Residents and faculty members should inform patients of**
1227 **their respective roles in each patient's care.**
1228
1229 **VI.D.2.** **The program must demonstrate that the appropriate level of**
1230 **supervision is in place for all residents who care for patients.**
1231
1232 **Supervision may be exercised through a variety of methods. Some**
1233 **activities require the physical presence of the supervising faculty**
1234 **member. For many aspects of patient care, the supervising**
1235 **physician may be a more advanced resident or fellow. Other**
1236 **portions of care provided by the resident can be adequately**
1237 **supervised by the immediate availability of the supervising faculty**
1238 **member or resident physician, either in the institution, or by means**
1239 **of telephonic and/or electronic modalities. In some circumstances,**
1240 **supervision may include post-hoc review of resident-delivered care**
1241 **with feedback as to the appropriateness of that care.**
1242
1243 **VI.D.3.** **Levels of Supervision**
1244
1245 **To ensure oversight of resident supervision and graded authority**
1246 **and responsibility, the program must use the following classification**
1247 **of supervision:**
1248
1249 **VI.D.3.a)** **Direct Supervision – the supervising physician is physically**
1250 **present with the resident and patient.**
1251
1252 **VI.D.3.b)** **Indirect Supervision:**
1253
1254 **VI.D.3.b).(1)** **with direct supervision immediately available – the**
1255 **supervising physician is physically within the hospital**
1256 **or other site of patient care, and is immediately**
1257 **available to provide Direct Supervision.**
1258
1259 **VI.D.3.b).(2)** **with direct supervision available – the supervising**
1260 **physician is not physically present within the hospital**
1261 **or other site of patient care, but is immediately**
1262 **available by means of telephonic and/or electronic**
1263 **modalities, and is available to provide Direct**
1264 **Supervision.**
1265
1266 **VI.D.3.c)** **Oversight – the supervising physician is available to provide**
1267 **review of procedures/encounters with feedback provided**
1268 **after care is delivered.**
1269
1270 **VI.D.4.** **The privilege of progressive authority and responsibility, conditional**
1271 **independence, and a supervisory role in patient care delegated to**
1272 **each resident must be assigned by the program director and faculty**
1273 **members.**
1274
1275 **VI.D.4.a)** **The program director must evaluate each resident's abilities**

1276 **based on specific criteria. When available, evaluation should**
1277 **be guided by specific national standards-based criteria.**
1278
1279 **VI.D.4.b)** **Faculty members functioning as supervising physicians**
1280 **should delegate portions of care to residents, based on the**
1281 **needs of the patient and the skills of the residents.**
1282
1283 **VI.D.4.c)** **Senior residents or fellows should serve in a supervisory role**
1284 **of junior residents in recognition of their progress toward**
1285 **independence, based on the needs of each patient and the**
1286 **skills of the individual resident or fellow.**
1287
1288 **VI.D.5.** **Programs must set guidelines for circumstances and events in**
1289 **which residents must communicate with appropriate supervising**
1290 **faculty members, such as the transfer of a patient to an intensive**
1291 **care unit, or end-of-life decisions.**
1292
1293 **VI.D.5.a)** **Each resident must know the limits of his/her scope of**
1294 **authority, and the circumstances under which he/she is**
1295 **permitted to act with conditional independence.**
1296
1297 **VI.D.5.a).(1)** **In particular, PGY-1 residents should be supervised**
1298 **either directly or indirectly with direct supervision**
1299 **immediately available.**
1300
1301 **VI.D.6.** **Faculty supervision assignments should be of sufficient duration to**
1302 **assess the knowledge and skills of each resident and delegate to**
1303 **him/her the appropriate level of patient care authority and**
1304 **responsibility.**
1305
1306 **VI.E.** **Clinical Responsibilities**
1307
1308 **The clinical responsibilities for each resident must be based on PGY-level,**
1309 **patient safety, resident education, severity and complexity of patient**
1310 **illness/condition and available support services.**
1311
1312 **VI.F.** **Teamwork**
1313
1314 **Residents must care for patients in an environment that maximizes**
1315 **effective communication. This must include the opportunity to work as a**
1316 **member of effective interprofessional teams that are appropriate to the**
1317 **delivery of care in the specialty.**
1318
1319 **VI.G.** **Resident Duty Hours**
1320
1321 **VI.G.1.** **Maximum Hours of Work per Week**
1322
1323 **Duty hours must be limited to 80 hours per week, averaged over a**
1324 **four-week period, inclusive of all in-house call activities and all**
1325 **moonlighting.**
1326

1327 **VI.G.1.a) Duty Hour Exceptions**
1328
1329 **A Review Committee may grant exceptions for up to 10% or a**
1330 **maximum of 88 hours to individual programs based on a**
1331 **sound educational rationale.**
1332
1333 The Review Committee for Allergy and Immunology will not
1334 consider requests for exceptions to the 80-hour limit to the
1335 residents' work week.
1336
1337 **VI.G.1.a).(1) In preparing a request for an exception the program**
1338 **director must follow the duty hour exception policy**
1339 **from the ACGME Manual on Policies and Procedures.**
1340
1341 **VI.G.1.a).(2) Prior to submitting the request to the Review**
1342 **Committee, the program director must obtain approval**
1343 **of the institution's GMEC and DIO.**
1344
1345 **VI.G.2. Moonlighting**
1346
1347 **VI.G.2.a) Moonlighting must not interfere with the ability of the resident**
1348 **to achieve the goals and objectives of the educational**
1349 **program.**
1350
1351 **VI.G.2.b) Time spent by residents in Internal and External Moonlighting**
1352 **(as defined in the ACGME Glossary of Terms) must be**
1353 **counted towards the 80-hour Maximum Weekly Hour Limit.**
1354
1355 **VI.G.2.c) PGY-1 residents are not permitted to moonlight.**
1356
1357 **VI.G.3. Mandatory Time Free of Duty**
1358
1359 **Residents must be scheduled for a minimum of one day free of duty**
1360 **every week (when averaged over four weeks). At-home call cannot**
1361 **be assigned on these free days.**
1362
1363 **VI.G.4. Maximum Duty Period Length**
1364
1365 **VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in**
1366 **duration.**
1367
1368 **VI.G.4.b) Duty periods of PGY-2 residents and above may be**
1369 **scheduled to a maximum of 24 hours of continuous duty in**
1370 **the hospital. Programs must encourage residents to use**
1371 **alertness management strategies in the context of patient**
1372 **care responsibilities. Strategic napping, especially after 16**
1373 **hours of continuous duty and between the hours of 10:00**
1374 **p.m. and 8:00 a.m., is strongly suggested.**
1375
1376 **VI.G.4.b).(1) It is essential for patient safety and resident education**
1377 **that effective transitions in care occur. Residents may**

1378 **be allowed to remain on-site in order to accomplish**
1379 **these tasks; however, this period of time must be no**
1380 **longer than an additional four hours.**
1381
1382 **VI.G.4.b).(2)** **Residents must not be assigned additional clinical**
1383 **responsibilities after 24 hours of continuous in-house**
1384 **duty.**
1385
1386 **VI.G.4.b).(3)** **In unusual circumstances, residents, on their own**
1387 **initiative, may remain beyond their scheduled period**
1388 **of duty to continue to provide care to a single patient.**
1389 **Justifications for such extensions of duty are limited**
1390 **to reasons of required continuity for a severely ill or**
1391 **unstable patient, academic importance of the events**
1392 **transpiring, or humanistic attention to the needs of a**
1393 **patient or family.**
1394
1395 **VI.G.4.b).(3).(a)** **Under those circumstances, the resident must:**
1396
1397 **VI.G.4.b).(3).(a).(i)** **appropriately hand over the care of all**
1398 **other patients to the team responsible**
1399 **for their continuing care; and,**
1400
1401 **VI.G.4.b).(3).(a).(ii)** **document the reasons for remaining to**
1402 **care for the patient in question and**
1403 **submit that documentation in every**
1404 **circumstance to the program director.**
1405
1406 **VI.G.4.b).(3).(b)** **The program director must review each**
1407 **submission of additional service, and track**
1408 **both individual resident and program-wide**
1409 **episodes of additional duty.**
1410
1411 **VI.G.5.** **Minimum Time Off between Scheduled Duty Periods**
1412
1413 **VI.G.5.a)** **PGY-1 residents should have 10 hours, and must have eight**
1414 **hours, free of duty between scheduled duty periods.**
1415
1416 **VI.G.5.b)** **Intermediate-level residents should have 10 hours free of**
1417 **duty, and must have eight hours between scheduled duty**
1418 **periods. They must have at least 14 hours free of duty after 24**
1419 **hours of in-house duty.**
1420
1421 First year allergy and immunology residents should be able to
1422 function as residents in the final years of education. However,
1423 some may come to residency with a specialized education and
1424 may only be at the PGY-2 or PGY-3 level. These residents should
1425 be monitored as “intermediate” residents for one year.
1426
1427 **VI.G.5.c)** **Residents in the final years of education must be prepared to**
1428 **enter the unsupervised practice of medicine and care for**

patients over irregular or extended periods.

VI.G.5.c).(1) **This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.**

VI.G.5.c).(1).(a) **Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.**

VI.G.5.c).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

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

Residents must not be scheduled for more than six consecutive nights of night float.

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

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

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

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

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

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

1480 **period".**
1481
1482 **VII. Innovative Projects**
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1484 **Requests for innovative projects that may deviate from the institutional, common**
1485 **and/or specialty specific program requirements must be approved in advance by**
1486 **the Review Committee. In preparing requests, the program director must follow**
1487 **Procedures for Approving Proposals for Innovative Projects located in the**
1488 **ACGME Manual on Policies and Procedures. Once a Review Committee approves**
1489 **a project, the sponsoring institution and program are jointly responsible for the**
1490 **quality of education offered to residents for the duration of such a project.**
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