Frequently Asked Questions: Internal Medicine Subspecialities

Review Committee for Internal Medicine

ACGME

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<tr><td colspan="2">Introduction</td></tr>
<tr><td>Is it possible to extend the required clinical experience beyond the accredited years of the program in order to provide fellows with an additional year for research?

[Program Requirements: Int.B. and C]</td><td>No. All required education must be completed within the accredited years. Additional year(s) of experience (i.e., for research) may be required or offered by the program, but all of the required experiences (as specified in the Program Requirements), must be completed during the accredited years.

Some programs encourage additional continuity clinic and clinical experiences during the additional unaccredited year. However, such expectations are beyond the required experiences.

Modifications of education for combined experiences (e.g., Critical Care – Infectious Diseases), or extended education for a Master of Public Health (MPH) degree, are considered case-by-case by the Review Committee and require prior approval based on an educational rationale, individual accommodation versus proposed routine program element, interrupted education (clinical and didactic), etc. All such considerations are expected to have prior approval from the program's Graduate Medical Education Committee (GMEC)/designated institutional official (DIO), and/or the American Board of Internal Medicine (ABIM).</td></tr>
<tr><td colspan="2">Institutions and Participating Sites</td></tr>
<tr><td>If a program recently developed an affiliation with another site that will provide salary support for additional fellows, may the fellowship develop a track for some of its fellows to spend most or all of their educational experiences at this site?

[Program Requirement: I.A.1]</td><td>No. Stand-alone fellowship tracks are not allowed.

The program may not establish a track for a subset of fellows who spend the majority of their experiences at a site separate from the core residency program.

Institutions may only sponsor a fellowship as a dependent subspecialty of the core internal medicine residency.

The fellowship must be at the same institution that sponsors the internal medicine residency, or may be based at a participating site where there is a continuous presence of the sponsoring institution's core internal medicine residents and faculty members.</td></tr>
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Question	Answer
	The fellowship may develop affiliations and rotations at other participating sites, as long as the fellows' continuity experience is maintained as required by the relevant program requirements for continuity clinic. The program director may excuse fellows from continuity clinic up to three non-consecutive months over a three-year fellowship, two non-consecutive months over a two-year fellowship, or one month for a one-year fellowship.
What portion of the program director's salary should be provided by the institution if it is a small program (e.g., a program with three fellows)? *[Program Requirement: I.A.2.b).(2)]*	The program director has many administrative responsibilities regardless of the size of the program. These include: developing and implementing the curriculum; planning and coordinating didactic conferences; evaluating the fellows/faculty members/program; giving feedback to fellows and faculty members; selecting faculty members for teaching assignments; conducting semi-annual reviews; preparing the program information form (PIF); implementing the competencies; and more. The Review Committee expects that that each program director will be provided with adequate time to fulfill these administrative responsibilities. Programs will be cited if the program director judges that the salary support is inadequate to cover the time spent carrying out the administrative responsibilities of the fellowship, or if the program director needs to generate clinical income to cover the cost of this administrative time. Note that 25-50 percent of a program director's salary is a range to account for the differences between small and large fellowship programs.
What are the Review Committee's expectations for programs with participating sites that are geographically distant or remotely located from the primary clinical site? *[Program Requirement: I.B.2]*	The Review Committee considers a participating site remote if it requires extended travel (consistently more than one hour each way) or if the radius between the site and the primary clinical site exceeds 60 miles. The Review Committee expects the following when participating sites are remote: 1. The program has provided appropriate educational rationale for the use of the remote site in the ACGME's Accreditation Data System (ADS). 2. The program director has final authority over all aspects of education at the remote site. 3. If experiences at the remote site will be required experiences, this information will need to be disclosed to all applicants prior to entering the program. 4. No more than 25 percent of the educational experience can occur at remote sites. 5. The program will need to ensure that fellows have housing available at the remote

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Question	Answer
	sites, at no cost to the fellows. 6. The program will need to establish a mechanism that allows: a) fellows to participate in conferences at the primary clinical site (electronically), or make conferences with similar educational value available at the remote site; b) faculty members at the remote site to interact with faculty members at the primary clinical site; c) fellows at the remote site to interact with other fellows at the primary clinical site; and, d) fellows to participate in interviews with the site visitor at the time of the program's scheduled ACGME site visit. *(July 2011 Review Committee meeting)**
Program Director	
Does the Review Committee allow co-program directors? *[Program Requirement: II.A.1]*	No, the Review Committee does not acknowledge co-program directors. The Review Committee expects there to be one individual with the responsibility and authority for all aspects of the educational program. Programs may identify an associate program director (i.e., a program director-in-training) who participates heavily in the operation and administration of the program under the direction of the program director. If an associate program director is identified, the Review Committee expects that this individual has sufficient administrative time and resources to devote to the program.
Does the Review Committee grant waivers to the program director if he or she does not have at least five years of participation as an active faculty member? *[Program Requirement: II.A.3.a).(1)]*	No, the Review Committee does not grant waivers to this requirement. This is a "must" requirement because the Review Committee feels strongly that five years as an internal medicine fellowship faculty member in an ACGME-accredited fellowship is an important prerequisite for taking on the role and responsibilities of program director. This experience allows individuals to gain fellowship and GME expertise, as well as institutional creditability to direct the fellowship and ensure compliance with the Program Requirements. Time spent in fellowship education does not count towards the five years of experience as an active faculty member.

Question	Answer
Does the Review Committee grant waivers for ABIM certification of the program director, if a program can demonstrate equivalent credentials? *[Program Requirement: II.A.3.b)]*	No, the Review Committee does not grant waivers for ABIM certification for program directors. The Review Committee uses ABIM certification as one of its major outcome measures. A major goal and outcome of each fellowship has been the education of ABIM-certified graduates. ABIM-certified program directors demonstrate to the fellows the value and importance of ABIM. The Review Committee will propose withholding of accreditation for applications where the program director does not have current ABIM certification in the subspecialty. The program director may allow his or her core internal medicine certification to lapse, but must maintain certification in the subspecialty.
Can the Committee be more specific about what it expects in regard to the program director's responsibility, authority, and accountability for the operation of the program? *[Program Requirements: II.A.1.-II.A.4.v)]*	The Review Committee expects that the program director will have full responsibility and full authority for all aspects of the fellowship. This includes: • The program director must monitor fellow experiences and exercise his or her authority when the need arises (i.e., addressing fellow complaints about a faculty member, or determining that a rotation has insufficient educational value, etc.). • The program director must have the authority to make all fellow assignments. • The program director must have the authority to revise clinical rotations as necessary to maintain fellow education. • The program director must have the authority to remove fellows from services he or she judges to have insufficient educational value. • The program director must have the authority to deny admitting privileges to the inpatient fellowship teaching service for selected physicians who fail to support the program. The program director must have the authority to remove selected faculty members from teaching assignments based on fellow evaluations or issues of faculty member competence/expertise. Authority may be shared (e.g., with the division chief), if the same effect can be demonstrated (i.e., resolution of problem faculty members, educationally marginal rotations).

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Question	Answer
Do the semi-annual evaluations of fellow performance need to be completed by the program director, or can these be delegated to another KCF member? *[Program Requirement: II.A.4.g)]*	The program director must perform all semiannual reviews personally.
What will the Review Committee accept as documentation of compliance with the duty hours requirements? *[Program Requirements: II.A.4.j)-k)]*	The Review Committee defers to programs and institutions the specifics of documentation of compliance with duty hours requirements. The Review Committee will rely on fellow reporting (i.e., the ACGME Resident and Fellow Survey, and the fellow interviews during the site visit) and review of fellow schedules in its accreditation decision regarding duty hours compliance. The Review Committee will consider additional information collected by the program (e.g., duty hour logs, periodic surveys, etc.) in its determination of compliance. Programs may be asked to respond to concerns identified in the ACGME Resident and Fellow Survey between site visits, and the Review Committee expects programs to be able to document substantial compliance.
What are examples of changes in the program for which the program director must request approval from the Review Committee? *[Program Requirement: II.A.4.o).(2)]*	The following are some examples of changes for which the program director must request approval from the Review Committee: • Major disruptions in the institutional affiliation, governance, stability, etc. require immediate Review Committee notification via ADS. • A major loss of program faculty (i.e., the program no longer meets the minimum number of KCF members as defined in the Program Requirements) requires immediate Review Committee notification as well as an update in ADS. • Programs must request approval for all complement increases, even temporary increases (i.e., maternity leave extends a fellow's education by three months such that when the fellow returns, the program is one over the limit). This is done in order to ensure that the information in ADS is accurate. Complement changes are very easily accomplished using ADS. Programs will need to complete the "Response to

Question	Answer
	Citations" in ADS prior to having a request for an increase in complement considered. Additionally, a request for an increase in complement will ask the program to provide documentation of adequate patient population, procedural opportunities, staff, facilities, faculty, research opportunities, and an educational rationale for the increase request. • The Review Committee understands that residents beginning and graduating off-cycle will occur frequently due to leaves of absence, remediation or visa delays. In these instances, a detailed educational rationale is not necessary. The program can briefly explain the reason for the off-cycle resident(s) in the Educational Rationale section of the request in webADS. (e.g. "Resident will be off-cycle for three months due to medical leave…"). These temporary increase requests for off-cycle residents can be reviewed and approved by RC-IM staff administratively. o The Review Committee will not grant a permanent increase: ▪ if the program's last accreditation status included a warning; ▪ during the interval between the time of the site visit and posting in ADS of the Letter of Notification (typically ~ 60 days following a Review Committee meeting); and, ▪ if the "Response to Citations" section in ADS has not been completed. Program directors must also request approval by the Review Committee for the following: • educational pathways for interrupted educational experiences (i.e., MPH programs that are sandwiched between accredited years of education) • adding a track (a program structure available to a subset of fellows in the program) or major alterations in program structure • education that results in an interruption to continuity clinic for six or more weeks (e.g., an overseas rotation) These requests will be reviewed in an expedited manner. The newly approved experience will be evaluated at a program's subsequent accreditation review. Program directors *do not* need to request approval for the following:

Question	Answer
	• individual (fellow-specific) variations in the program (e.g., parental leave, medical leave of absence, etc.) • individual (fellow-specific) interruptions in education that are not part of an established curricular pathway (e.g., an individual fellow obtaining an MPH or PhD between Years 1 and 3) • appointment of fellows in additional non-accredited years (e.g., extra year of research) who therefore do not count against complement • temporary reduction in complement
How should a program director monitor fellow stress? *[Program Requirement: II.A.4.p)]*	The Review Committee expects that the program director will monitor the well-being of fellows through a variety of sources: faculty member evaluations, peer and other 360 evaluations, semiannual reviews, administrative meetings with fellows, reports from KCF members, and day-to-day observations. Fellows should feel comfortable discussing concerns and problems with the faculty members and program director. The program director should make appropriate interventions (i.e., referral of a fellow to an employee assistance program) as needed.
How can a program director demonstrate compliance with the requirement that he or she must enhance his or her educational and administrative skills? *[Program Requirement: II.A.4.s)]*	The program director can demonstrate his or her commitment to continuing medical education and to improving both education (teaching, specialty expertise) and administrative (GME) skills by attending Association of Program Directors in Internal Medicine (APDIM) or Alliance for Academic Internal Medicine (AAIM) meetings, ACGME conferences, fellowship program director meetings, and other similar meetings.
Why does the Review Committee expect the fellowship program director have a reporting relationship with the internal medicine residency program director? If the program meets periodically to discuss the relationship between fellows and residents in the hospital, will this meet the Committee's expectations? *[Program Requirement: II.A.4.t)]*	The Review Committee expects that each program director will report to the core internal medicine residency program director. The purpose of this requirement is to ensure that the fellowship program director uses the experience and oversight of the core residency program director to: • understand and comply with the fellowship program requirements; • understand and implement competency-based educational program, quality improvement (QI) projects, etc.; and, • ensure that the fellowship and core residency program directors coordinate changes in their respective programs that may have an impact on either program. The Review Committee expects the core internal medicine program director to provide

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	oversight of all internal medicine fellowship programs. Oversight may be accomplished in a variety of ways, such as: • joint participation in a departmental fellowship committee; • joint meetings with the DIO; or, • periodic meetings between the residency and fellowship program directors. Note: Simply meeting to discuss interface of fellows and residents, resident rotations, etc. is insufficient. The Review Committee will examine each fellowship carefully for the presence of the core internal medicine residency program director's oversight of the fellowship. The fellowship program director will be cited when a reporting relationship to the core internal medicine residency program director is not clearly present. The internal medicine program director will be cited when multiple subspecialties have similar citations (e.g., curriculum, evaluation, continuity clinic) suggesting lack of oversight for compliance with fellowship Program Requirements. For sub-subspecialties, the Review Committee expects the parent subspecialty (e.g., cardiology) program director to provide oversight of the sub-subspecialty (e.g., interventional cardiology) program director. This oversight can be through the parent subspecialty (e.g., internal medicine → cardiology → interventional cardiology) or simultaneous (i.e., internal medicine → cardiology and interventional cardiology) but the effect must be the same.
Faculty	
How many publications are required of key clinical faculty (KCF) members? Can abstracts and presentations at specialty meetings be counted toward the requirement? *(Program Requirement II.B.5)*	The Review Committee requires that fellowship education occurs in an environment of inquiry, scholarship, and research productivity. The Review Committee requires that KCF demonstrate both *participation* and *productivity* in scholarship of discovery and dissemination as evidenced by: • *Participation* Expectation: 50% of the certified, minimum-required-number of KCF must demonstrate at least one acceptable product of scholarship in the past three years. (See definition of acceptable products of scholarship below) • *Productivity* Expectation: Total acceptable scholarly products for KCF and non-KCF (There must be at least one product per year x three years x the 50% of the

Question	Answer

	minimum required KCF. The non-KCF are counted as long as they contribute to fellow education and devote at least 10 hours a week to the program.
	
	Acceptable Products of Scholarship
	The Review Committee defines acceptable products of scholarship as follows:
	• Publication of original research manuscripts in a peer-review journal
	• Publication of a review article in a peer-review journal
	• Publication of an editorial in a peer-review journal
	• Publication of a book chapter published in medical textbooks (full citation required including publisher and date)
	  o This includes chapters published in specialty society review texts, such as MKSAP, NephSAP, ACCSAP, the Geriatrics Review Syllabus, etc.
	• Publication of a case report indexed in PubMed
	  o A copy of the case report must be included
	  o Case reports published as an abstract, letter, correspondence, or illustration do not count
	• Peer-review funding of research such as NIH, NCI, or other external funding organizations
	• In press or accepted for publication in a peer-review journal
	
	The following *will not* fulfill requirements for scholarship:
	• Submitted or in preparation
	• Abstracts, letters-to-editor, correspondence, or illustrations
	• Case reports published as an abstract, letter, correspondence, or illustration
	• Non-peer-review publications
	• Non-peer review funding, such as industry funding, or internal institutional funding, or multicenter industry funding, or other non-peer-review grant
	  o Exception: Pharmaceutical studies in which the KCF is the overall PI (lead investigator) for all sites will be accepted as counting as one product of scholarship
	
	The Review Committee expanded its expectation for *participation* in scholarship to include the “Acceptable *Products* of Scholarship” as listed above as well as the following:
	  o Presentations at national, international or regional meetings

Question	Answer
	○ Leadership roles in national medical organizations or serving as a reviewers or editorial board members for peer-reviewed journals This broadened expectation does not extend to scholarly *productivity*. Scholarly *products* are limited to what appears above under the title "Acceptable *Products* of Scholarship." Summary/Example: • For an application for a new six-fellow endocrinology program there must be four KCF (which includes the program director). • In order to meet the *Participation* Expectation, two of the four KCF must have evidence of a scholarly project or activity from the last three calendar years. • In order to meet the *Productivity* Expectation, there must be at least six scholarly products across the KCF and non-KCF. Note: • Publications with several KCF as authors can only be counted once • "Last three calendar years" means that the Review Committee will count the scholarly products (as defined above) from 2011, 2012, 2013, and 2014 for an application that is submitted in 2014. See summary of KCF minimum numbers and research productivity in **Appendix I**
Does the Review Committee grant waivers for ABIM certification for the KCF? *[Program Requirement: II.B.7.a).(2)]*	The Review Committee applies the ABIM faculty certification requirement to the program director and the minimum number of required KCF members. *There is no substitute or exception for ABIM certification*. The minimum number of required KCF members (the minimum number varies by fellowship and by the number of fellows approved) must be ABIM-certified and must maintain certification in the subspecialty. As noted earlier for the program director, fellowship KCF members may allow internal medicine certification to lapse, but must maintain current certification in the subspecialty. However, additional KCF members (over the minimum number required) are not *required* to hold and maintain ABIM certification. Such KCF members' scholarly activity will not count toward the KCF scholarship <u>participation</u>, but may contribute to the KCF scholarship <u>productivity</u> requirement if they meet all other KCF criteria.

Question	Answer
	KCF members in clinical cardiac electrophysiology (CCEP) or interventional cardiology (IC) must maintain subspecialty certification in cardiology and sub-subspecialty certification in CCEP or IC. Transplant hepatology KCF members must maintain certification in gastroenterology and sub-subspecialty certification in transplant hepatology. Non-KCF/other faculty members do not need ABIM certification.
What is acceptable education for KCF members who will serve as competency evaluators? *[Program Requirement: II.B.7.b).(3).(a)]*	Acceptable education for KCF members who will serve as competency evaluators can be achieved through participation in workshops offered through the fellowship organizations/societies or colleges (APDIM/AAIM, ABIM, ACGME), or through local GME faculty development programs that focus on competency assessment. The evaluator(s) are expected to have ongoing education in these areas. The program should be able to document that the evaluators have been active in the assessment of fellows.
What does the Review Committee expect programs to do to be in compliance with the requirement that KCF members should participate in faculty development programs? *[Program Requirement: II.B.8]*	The program director and/or the DIO are expected to organize and provide continuing medical education activities for faculty members regarding fellowship education and the competencies. • This faculty development can occur in a variety of ways (e.g., faculty meetings, web-based faculty curricula, assigned readings, e-mail updates, focused instruction, etc.) that promote continuous improvement of the faculty. • Locally organized meetings are acceptable (and encouraged). • Faculty member attendance at specialty meetings alone is insufficient, unless special sessions on fellowship education and competencies are included in the sessions attended.
Resources	
What does the Review Committee consider as examples of electronic health record (EHR)? *[Program Requirement: II.D.5]*	Fellows should have access to an electronic health record (EHR) at least at one site used for clinical training. An EHR can include electronic notes, orders, and lab reporting. Such a system also facilitates data reporting regarding the care provided to a patient or a panel of patients. It may also include systems for enhancing the quality and safety of patient care. An EHR does not have to be present at all participating sites and does not have to be comprehensive. A system that simply reports lab or radiology results does not meet this definition of an EHR.
Educational Program	
Is there a suggested number of	There are no specific requirements for the number of conferences per month. This

Question	Answer
conferences or frequency of conferences per month, and how will programs be assessed for compliance? *[Program Requirement: IV.A.3.(a)]*	requirement allows the program director flexibility to schedule conferences in a manner that best meets the needs of the program. The Review Committee will look at several variables in assessing the adequacy of a program's didactic sessions. Programs may be cited if: • instruction is lacking in one of the content areas defined in the Subspecialty Program Requirements (primarily sections IV.A.5 – Patient Care, and IV.A.6 – Medical Knowledge); • all conference types listed in the Program Requirements (above) are not included in the curriculum; or, • the frequency of conferences is not sufficient to maintain the environment of inquiry and scholarship that is expected, based on information obtained from fellow surveys and/or during a site visit.
What can programs do to offer fellows the opportunity to recoup or make up missed conferences? *[Program Requirement: IV.A.3.a).(1)]*	There must be a mechanism for fellows who miss conferences (day off, post-call, vacation, off-campus rotation, etc.) to make up the missed educational experience. The Review Committee accepts a variety of solutions, as long as fellows have the opportunity to experience missed conferences. The solutions to this issue are all local, and depend partially on why fellows miss a conference(post-call, day-off, away rotation). A variety of solutions are acceptable, such as: • videotaping • web casting • making slides available online • repeating conferences • offering a parallel conference series at the off-site location
What constitutes adequate instruction in practice management? *[Program Requirement: IV.A.3.c)]*	Instruction in practice management includes the organization and financing of clinical practice. including personnel and business management, scheduling, billing and coding procedures, telephone and telemedicine management, and maintenance of an appropriate confidential patient record system.

Question	Answer
What does the Review Committee expect in regards to integrating competencies into the curriculum? *[Program Requirement: IV.A.5]*	The Review Committee will examine the fellowship carefully at the time of each accreditation review for evidence of the following: • a competency-based written curriculum; • awareness and understanding of the competencies and outcomes by all fellows; and, • awareness and understanding of the competencies and outcomes by faculty members.
How can fellowship programs meet the requirement for an appropriate distribution of patients of both sexes, with a broad age range, including geriatric patients? *[Program Requirements: IV.A.5.a).(1) and IV.A.6.c).(2)]*	The gender standard can be averaged over the duration of the program. Over the duration of accredited program, the patient population is expected to consist of at least 25 percent from each gender. The standard is applied primarily to continuity clinics. However, if the inpatient experience is exclusively (or nearly so) male or female, the program will be cited for gender inadequacy. • If the inpatient or outpatient experience lacks exposure to geriatric patients, the program will be cited for inadequate exposure to the geriatric population. Programs can use Veterans Affairs' clinics in six-month blocks combined with non-Veterans Affairs' clinics, as long as the gender mix over the duration of the accredited program is at least 25 percent averaged across each fellow's continuity clinics.
What is an acceptable assessment of a fellow's demonstration of high standards of ethical behavior? *[Program Requirement: IV.A.5.e).(6)]*	These qualities can be assessed using multi-source evaluation.
What does the Review Committee consider "training using simulation"? *[Program Requirement: IV.A.6.b)]*	The Review Committee does NOT expect each program to use a simulator or have a simulation center. Simulation means that learning about patient care occurs in a setting that does not include actual patients. This could include objective structured clinical examinations (OSCEs), standardized patients, patient simulators, or electronic simulation of codes, procedures, and other clinical scenarios.
How does the Review Committee expect programs to structure fellows' continuity experience?	Fellowships may organize their continuity clinics in either the traditional weekly clinic over the duration of the program, or in blocks of weekly clinics at least six months in duration. Please note:

Question	Answer
[Program Requirement: IV.A.6.c)]	• The continuity clinic must occur throughout the duration of the accredited program, including research time. • Time spent in continuity clinic cannot be deducted from required clinical experiences. • If the program uses alternating continuity clinics (i.e., every other week), then the minimum block allowed is 12 months. • The Review Committee no longer requires tracking of new and return patients. ○ 4-8 patients is averaged over the year, and applies only to continuity clinic (not to other ambulatory experiences). • There is no rule in the fellowships specifying the minimum number of weekly clinics per fellow. Therefore the program director may excuse fellows from up to one month of continuity clinic per year (not counting vacation).
Are blocks devoted exclusively to research allowed? *[Program Requirements: IV.B.1-IV.B.1.c)]*	No. Research may occur in blocks only if clinical experiences are concurrently present through all 12 months, including during the research blocks. Research blocks are not required; scholarship can be conducted by other methods.

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Question	Answer

What are the Review Committee's expectations for research/scholarship requirements for fellows and must all fellows publish?
 	
[Program Requirement: IV.B.2.a)]
	The Review Committee expects fellows to demonstrate evidence of productivity in scholarship.
	
	• This productivity can be scholarship of discovery or dissemination (the KCF standard) or scholarship of application, such as abstracts and presentations.
	• The productivity must reflect research/scholarship completed during the fellowship, although publication/presentation may occur after a fellow completes the program.
	• At the time of PIF submission, at least 50 percent of a program's fellows in the previous three graduating classes must demonstrate at least one of the following:
	    o manuscript(s) published
	    o case Reports published
	    o abstract(s) published in journal, or specialty abstract book
	    o abstract(s) presented at national specialty society meeting
	• Fellows in geriatric medicine or one-year critical care medicine programs will not be required to demonstrate evidence of research/scholarly productivity.
	• Fellows in two-year critical care medicine programs will need to meet the fellow research/scholarly productivity requirements.
	• Fellows in CCEP, IC, transplant hepatology, and sleep medicine programs must participate in scholarly activity that is more broadly defined because of the limited duration of these educational programs (i.e., research projects, enrollment of patients in clinical trials, or QI/performance improvement projects). Review the Program Requirements for CCEP, IC, transplant hepatology and sleep medicine for specifics on expectations.

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Question	Answer
Evaluation	
If a program uses an electronic evaluation system, do paper records need to be maintained as well? *[Program Requirement: V.A.1.a)]*	A paper record of evaluations must be kept for: • the summative evaluation at the completion of education; and, • fellows with academic or other performance problems, as the electronic evaluation parameters may not be appropriate or sufficient in cases where remediation, probation, non-renewal, or dismissal needs to be documented. All other electronic records are sufficient and do not need to be archived in print format as long as they are securely maintained, backed up, and accessible for use by fellows, the program, and the institution.
Why would a program receive a citation for inadequate faculty feedback if the faculty return rate on evaluations is extremely high? *[Program Requirement: V.A.1.a).(1)]*	The review committee expects that <u>all</u> faculty members complete and return a written or electronic evaluation form and provide each fellow with verbal, face-to-face feedback at the completion of each rotation. Faculty members must do both. A citation may occur if it is reported that some faculty consistently do not provide this feedback <u>OR</u> if the faculty members have not provided verbal face-to-face feedback at the completion of each rotation on a consistent basis.
What outcomes must be documented in fellows' logbooks of required procedures? *[Program Requirement: V.A.1.b).(1).(a).(ii)]*	Findings, interventions, and complications must be documented by fellows in their logbooks of required procedures.
How should fellows be assessed relative to the competencies? *[Common Program: Requirement V.A.1.b).(1)]*	The Review Committee expects programs to develop metrics and instruments to evaluate and measure competency in each of the content areas. This includes: • competency-based semiannual reviews by the program director • competency-based global ratings by faculty members • competency-based advancement criteria revised • use of direct observation and reflection exercises to assess competency (i.e., mini-clinical evaluation exercise (CEX), OSCE, checklists, simulators, etc.) • use of practice-based learning and improvement exercises to assess competency (i.e., chart audit, portfolios, vignettes, chart stimulated recall, etc.) • a system to log procedural competency with procedure logs

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Question	Answer
	• use of multi-source (360) evaluations to assess competency (i.e., patients, peers, nurses, etc.) • use of competency-based summative evaluations
What is expected for the multi-source evaluations? *[Program Requirement: V.A.1.b).(2)]*	The goal is to obtain feedback from multiple evaluators who interact with the fellow being assessed. These must include at least patients, peers, and non-physician team members (nurses, clerical staff, therapists, etc.). The evaluation forms distributed to these individuals do not have to ask the same items, but should reflect the general domain(s) being assessed (e.g., interpersonal and communication skills, professionalism, systems-based practice).
Are competency-based semi-annual evaluations required? *[Program Requirement: V.A.1.b).(4)]*	Yes. In addition to the program director personally performing the evaluations, feedback on performance related to each of the six ACGME competencies must be documented either on a standardized form or by narrative.
How must fellow performance in continuity clinic be evaluated? *[Program Requirement: V.A.1.b).(4).(a)]*	Fellow performance in continuity clinic must be evaluated by faculty members with whom the fellows have a significant, longitudinal, precepting relationship. A distinct evaluation tool for this experience may make documentation efficient. The program director may provide a fellow's semiannual feedback only if he or she has a direct precepting relationship with that fellow.
What are the elements of a summative fellow evaluation? *[Program Requirements: V.A.2.-V.A.2.b)]*	Programs must prepare a final ("summative") evaluation for each fellow. That review must summarize performance during the final period of the fellowship. It should include verification of a fellow's professional competency to enter the practice of medicine without supervision. While the final summary statement does not need to use the exact words "demonstrated sufficient professional ability to practice competently and independently," the final verification must contain an equivalent statement that attests to a fellow's professional competency to begin practice in that specialty. The summative evaluation must be maintained for future credentialing, privileging, and letters of evaluation. Use of the ABIM Tracking Form alone does not fulfill the requirement for a summative evaluation.
What are the elements of faculty member evaluations? *[Program Requirement: V.B.3]*	Each fellow must have the opportunity to evaluate each faculty member with whom he or she works at the end of each rotation period. • These evaluations must be confidential. ○ The faculty member evaluation does not need to be anonymous, however, confidentiality means that the faculty members being evaluated are blinded to

Question	Answer
	the identity of the fellows completing the evaluations. ▪ Signed faculty member evaluation forms potentially violate fellow confidentiality, and are therefore prohibited. ▪ The program may track returns of the evaluations (i.e., by tracking electronic evaluations, or by having the return envelopes signed) as long as the program takes special precautions to ensure that the names of fellows are used only to track returns, and are never available to the faculty members being evaluated. • Fellows' evaluations of faculty members must be reviewed with the faculty members annually. • The program must use the fellow evaluations for selection of faculty members for teaching assignments.
What are the Review Committee's expectations for fellows' evaluations of faculty members if circumstances make it difficult to complete the evaluation at the end of a specific rotation? *[Program Requirements: V.B.3.a)-b)]*	The Review Committee acknowledges that some attending assignments to teaching activities may not be tightly linked to the month-long delimited rotations/assignments. For such situations, evaluations of faculty members do not need to not take place at the end of the monthly rotation, since the fellow may not have had enough exposure to one particular attending to meaningfully evaluate him or her. However, in such situations, at a minimum, the Review Committee expects that fellows will evaluate the attending's performance/teaching ability at least quarterly. *(July 2011 Review Committee meeting)*
For those subspecialties in which Board certification exams are only offered on alternate years, how will the Review Committee interpret Board take and pass rates? *[Program Requirement: V.C.1.c)]*	The Review Committee is aware that a few subspecialties only offer Board exams every other year, and will take that into account when considering Board take and pass rates during program review.
What are the elements for program evaluation? *[Program Requirements: V.C.1.-2]*	Programs must have a process in place for an annual program review of faculty members, the curriculum, the facilities, etc. This process is separate and distinct from the GMEC internal reviews that are required by the ACGME Institutional Review Committee at the midpoint of a program's accreditation cycle. The review panel must include at least one fellow and at least one faculty member. The results of the review must be documented by minutes and a summary report. The annual review process must include documented review of:

Question	Answer
	• faculty member evaluations of the program • fellow evaluations of the program and faculty members • utilization of the resources available to the program • contribution of each institution participating in the program • financial and administrative support of the program • volume and variety of patients available to the program for educational purposes • effectiveness of inpatient and ambulatory teaching • performance of faculty members • quality of supervision of fellows If a program has a process to perform this function monthly (i.e., a standing committee made up of the program director, KCF members, and fellow representatives), then this may meet the requirements. However, the evaluation of the program is more than just the summary of all end-of-rotation evaluations. It must include the evaluation of the total didactic and clinical program (curriculum, faculty, conferences, etc.).
Fellow Duty Hours in the Learning and Working Environment	
Must every interprofessional team include representations from every profession listed in the requirement? *[Program Requirement: VI.F]*	No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The intent of the requirement is to ensure that the program has access to these professional and paraprofessional personnel and that interprofessional teams will be constituted as appropriate and as needed.

** Parenthetical dates following responses indicate the Review Committee meeting at which that FAQ was discussed and added to the document. Note: the Review Committee for Internal Medicine began tracking additions of FAQs beginning in January 2011.*

07/2012

Appendix I

Review Committee for Internal Medicine Calculation of Minimum Key Clinical Faculty (KCF) and KCF Scholarship Participation/Productivity Endocrinology, Infectious Diseases, Rheumatology, Geriatrics, and Transplant Hepatology Minimum 3 KCF or 1:1.5 faculty-fellow ratio for programs with 4 or more fellows				
Approved Fellow Complement	**Minimum Certified KCF (incl PD)**	**Majority of Minimum KCF (50%)**	***PARTICIPATION*** **KCF with at Least 1 Scholarly Activity in Past 3 Years**	***PRODUCTIVITY*** **Pubs for All KCF & non-KCF in Past 3 Years (1/yr x 3 yrs)**
2	2	1	1	3
3	2	1	1	3
4	3	2	2	6
5	3	2	2	6
6	4	2	2	6
7	5	3	3	9
8	5	3	3	9
9	6	3	3	9
10	7	4	4	12
11	7	4	4	12
12	8	4	4	12
13	9	5	5	15
14	9	5	5	15
15	10	5	5	15
16	11	6	6	18
17	11	6	6	18
18	12	6	6	18
19	13	7	7	21
20	13	7	7	21
21	14	7	7	21
22	15	8	8	24
23	15	8	8	24
24	16	8	8	24
25	17	9	9	27
26	17	9	9	27
27	18	9	9	27
28	19	10	10	30
29	19	10	10	30
30	20	10	10	30

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Review Committee for Internal Medicine Calculation of Minimum Key Clinical Faculty (KCF) and KCF Scholarship Participation/Productivity Hematology, Oncology, Nephrology, and Pulmonary Disease Minimum 3 KCF or 1:1.5 faculty-fellow ratio for programs with 5 or more fellows				
Approved Fellow Complement	**Minimum Certified KCF (incl PD)**	**Majority of Minimum KCF - (50%)**	**PARTICIPATION KCF with at Least 1 Pub Past 3 Years**	**PRODUCTIVITY Pubs All KCF Past 3 Years (1/yr x 3 yrs)**
2	3	2	2	6
3	3	2	2	6
4	3	2	2	6
5	3	2	2	6
6	4	2	2	6
7	5	3	3	9
8	5	3	3	9
9	6	3	3	9
10	7	4	4	12
11	7	4	4	12
12	8	4	4	12
13	9	5	5	15
14	9	5	5	15
15	10	5	5	15
16	11	6	6	18
17	11	6	6	18
18	12	6	6	18
19	13	7	7	21
20	13	7	7	21
21	14	7	7	21
22	15	8	8	24
23	15	8	8	24
24	16	8	8	24
25	17	9	9	27
26	17	9	9	27
27	18	9	9	27
28	19	10	10	30
29	19	10	10	30
30	20	10	10	30

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Review Committee for Internal Medicine Calculation of Minimum Key Clinical Faculty (KCF)
and
KCF Scholarship Participation/Productivity
Cardiovascular Disease
Minimum 4 KCF or 1:1.5 faculty-fellow ratio for programs with 7 or more fellows

Approved Fellow Complement	Minimum Certified KCF (incl PD)	Majority of Minimum KCF (50%)	PARTICIPATION KCF with at Least 1 Pub Past 3 Years	PRODUCTIVITY Pubs All KCF Past 3 Years (1/yr x 3 yrs)
2	4	2	2	6
3	4	2	2	6
4	4	2	2	6
5	4	2	2	6
6	4	2	2	6
7	5	3	3	9
8	5	3	3	9
9	6	3	3	9
10	7	4	4	12
11	7	4	4	12
12	8	4	4	12
13	9	5	5	15
14	9	5	5	15
15	10	5	5	15
16	11	6	6	18
17	11	6	6	18
18	12	6	6	18
19	13	7	7	21
20	13	7	7	21
21	14	7	7	21
22	15	8	8	24
23	15	8	8	24
24	16	8	8	24
25	17	9	9	27
26	17	9	9	27
27	18	9	9	27
28	19	10	10	30
29	19	10	10	30
30	20	10	10	30

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Review Committee for Internal Medicine Calculation of Minimum Key Clinical Faculty (KCF) and KCF Scholarship Participation/Productivity Gastroenterology Minimum 4 KCF or 1:1.5 faculty-fellow ratio for programs with 7or more fellows						
Approved Fellow Compleme nt	**Minimum Certified KCF (incl PD)**	**Minimum Hepatology KCF (incl PD)**	**Minimum Advanced Endoscopy KCF (incl PD)**	**Majority of Minimum KCF (50%)**	**PARTICIPATION KCF with at Least 1 Pub Past 3 Years**	**PRODUCTIVITY Pubs All KCF Past 3 Years (1/yr x 3 yrs)**
2	4	1	1	2	2	6
3	4	1	1	2	2	6
4	4	1	1	2	2	6
5	4	1	1	2	2	6
6	4	1	1	2	2	6
7	5	1	1	3	3	9
8	5	1	1	3	3	9
9	6	1	1	3	3	9
10	7	1	1	4	4	12
11	7	1	1	4	4	12
12	8	1	1	4	4	12
13	9	1	1	5	5	15
14	9	1	1	5	5	15
15	10	1	1	5	5	15
16	11	1	1	6	6	18
17	11	1	1	6	6	18
18	12	1	1	6	6	18
19	13	1	1	7	7	21
20	13	1	1	7	7	21
21	14	1	1	7	7	21
22	15	1	1	8	8	24
23	15	1	1	8	8	24
24	16	1	1	8	8	24
25	17	1	1	9	9	27

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Review Committee for Internal Medicine Calculation of Minimum Key Clinical Faculty (KCF) and KCF Scholarship Participation/Productivity Hematology/Medical Oncology Minimum 6 KCF or 1:1.5 faculty-fellow ratio for programs with 10 or more fellows						
Approved Fellow Complement	**Minimum Certified KCF (incl PD)**	**Minimum Certified HEME KCF (incl PD)**	**Minimum Certified ONC KCF (incl PD)**	**Majority of Minimum KCF (50%)**	**PARTICIPATION KCF with at Least 1 Pub Past 3 Years**	**PRODUCTIVITY Pubs All KCF Past 3 Years (1/yr x 3 yrs)**
2	6	3	3	3	3	9
3	6	3	3	3	3	9
4	6	3	3	3	3	9
5	6	3	3	3	3	9
6	6	3	3	3	3	9
7	6	3	3	3	3	9
8	6	3	3	3	3	9
9	6	3	3	3	3	9
10	7	4	4	4	4	12
11	7	4	4	4	4	12
12	8	4	4	4	4	12
13	9	5	5	5	5	15
14	9	5	5	5	5	15
15	10	5	5	5	5	15
16	11	6	6	6	6	18
17	11	6	6	6	6	18
18	12	6	6	6	6	18
19	13	7	7	7	7	21
20	13	7	7	7	7	21
21	14	7	7	7	7	21
22	15	8	8	8	8	24
23	15	8	8	8	8	24
24	16	8	8	8	8	24
25	17	9	9	9	9	27

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Review Committee for Internal Medicine Calculation of Minimum Key Clinical Faculty (KCF)
and
KCF Scholarship Participation/Productivity
Pulmonary Disease/Critical Care Medicine
Minimum 6 KCF or 1:1.5 faculty-fellow ratio for programs with 10 or more fellows

Approved Fellow Complement	Minimum Certified KCF (incl PD)	Minimum Certified PULM KCF (incl PD)	Minimum Certified CC KCF (incl PD)	Majority of Minimum KCF (50%)	PARTICIPATION KCF with at Least 1 Pub Past 3 Years	PRODUCTIVITY Pubs All KCF Past 3 Years (1/yr x 3 yrs)
2	6	3	3	3	3	9
3	6	3	3	3	3	9
4	6	3	3	3	3	9
5	6	3	3	3	3	9
6	6	3	3	3	3	9
7	6	3	3	3	3	9
8	6	3	3	3	3	9
9	6	3	3	3	3	9
10	7	3 or 4*	3 or 4*	4	4	12
11	7	3 or 4*	3 or 4*	4	4	12
12	8	4	4	4	4	12
13	9	4 or 5*	4 or 5*	5	5	15
14	9	4 or 5*	4 or 5*	5	5	15
15	10	5	5	5	5	15
16	11	5 or 6*	5 or 6*	6	6	18
17	11	5 or 6*	5 or 6*	6	6	18
18	12	6	6	6	6	18
19	13	6 or 7"	6 or 7"	7	7	21
20	13	6 or 7"	6 or 7"	7	7	21
21	14	7	7	7	7	21
22	15	8 or 9*	8 or 9*	8	8	24
23	15	8 or 9*	8 or 9*	8	8	24
24	16	8	8	8	8	24
25	17	9 or 10*	9 or 10*	9	9	27

*Where odd number of KCF is required, program may have an uneven number, such as 3 CCM and 4 Pulm KCF for a required KCF of 7. Faculty members with dual board certification can be counted as either Pulm or CCM.

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Review Committee for Internal Medicine Calculation of Minimum Key Clinical Faculty (KCF) and KCF Scholarship Participation/Productivity Critical Care Medicine Minimum 3 KCF or 1:1 faculty-fellow ratio for programs with 4 or more fellows				
Approved Fellow Complement	**Minimum Certified KCF (incl PD)**	**Majority of Minimum KCF (50%)**	**PARTICIPATION KCF with at Least 1 Pub Past 3 Years**	**PRODUCTIVITY Pubs All KCF Past 3 Years (1/yr x 3 yrs)**
2	3	2	2	6
3	3	2	2	6
4	4	2	2	6
5	5	3	3	9
6	6	3	3	9
7	7	4	4	12
8	8	4	4	12
9	9	5	5	15
10	10	5	5	15
11	11	6	6	18
12	12	6	6	18
13	13	7	7	21
14	14	7	7	21
15	15	8	8	24
16	16	8	8	24
17	17	9	9	27
18	18	9	9	27
19	19	10	10	30
20	20	10	10	30

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Review Committee for Internal Medicine Calculation of Minimum Key Clinical Faculty (KCF) and KCF Scholarship Participation/Productivity Clinical Cardiac Electrophysiology and Interventional Cardiology Minimum 2 KCF or 1:1.5 faculty-fellow ratio for programs with 3 or more fellows				
Approved Fellow Complement	**Minimum Certified KCF (incl PD)**	**Majority of Minimum KCF (50%)**	**PARTICIPATION KCF with at Least 1 Pub Past 3 Years**	**PRODUCTIVITY Pubs All KCF Past 3 Years (1/yr x 3 yrs)**
2	2	1	1	3
3	2	1	1	3
4	3	2	2	6
5	3	2	2	6
6	4	2	2	6
7	5	3	3	9
8	5	3	3	9
9	6	3	3	9
10	7	4	4	12

Review Committee for Internal Medicine Calculation of Minimum Key Clinical Faculty (KCF) and KCF Scholarship Participation/Productivity Sleep Medicine Minimum 2 KCF or 1:2 faculty-fellow ratio for programs with 5 or more fellows				
Approved Fellow Complement	**Minimum Certified KCF (incl PD)**	**Majority of Minimum KCF (50%)**	**PARTICIPATION KCF with at Least 1 Pub Past 3 Years**	**PRODUCTIVITY Pubs All KCF Past 3 Years (1/yr x 3 yrs)**
2	2	1	1	3
3	2	1	1	3
4	2	1	1	3
5	3	2	2	6
6	3	2	2	6
7	4	2	2	6
8	4	2	2	6
9	5	3	3	9
10	5	3	3	9

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Appendix II

Review Committee for Internal Medicine Required Procedure Log Documentation for Internal Medicine Subspecialties

The General Program Requirements for Internal Medicine Subspecialties require documentation of procedural experience and tracking of this experience by the program.

The Review Committee for Internal Medicine requires documentation of procedural experience for the procedures listed in the tables below. Additional (optional) procedures may be documented, but all fellows in the subspecialty must log and track the required procedures.

Subspecialty	Procedures that Must be Documented
Cardiology	1. Elective cardioversion 2. Insertion and management of temporary pacemakers, including transvenous and transcutaneous 3. Programming and follow-up surveillance of permanent pacemakers 4. Bedside right heart catheterization 5. Right and left heart catheterization including coronary arteriography 6. Exercise stress testing 7. Echocardiography, including transesophageal cardiac studies
Clinical Cardiac Electrophysiology	1. Electrophysiology invasive diagnostic/interventional catheter procedures 2. Intracardiac procedures related to supraventricular arrhythmia 3. Electrode catheter introduction 4. Electrode catheter positioning in atria, ventricles, coronary sinus, His bundle area, and pulmonary artery 5. Stimulating techniques to obtain conduction times and refractory periods and to initiate and terminate tachycardias 6. Therapeutic catheter ablation procedures 7. Implantation of cardioverter/defibrillators and pacemakers
Interventional Cardiology	1. Right and left heart catheterization including coronary arteriography, ventriculography, and hemodynamic measurements 2. Intravascular ultrasound 3. Doppler flow, intracoronary pressure measurement and monitoring, and coronary flow reserve 4. Coronary interventions 5. Femoral and brachial/radial cannulation of normal and abnormally located coronary ostia 6. Application and usage of balloon angioplasty, stents, and other commonly used interventional devices
Critical Care Medicine	1. Chest tube insertion 2. Endotracheal intubation 3. Arterial Line insertion 4. Central venous line insertion 5. Pulmonary artery catheter insertion 6. Thoracentesis 7. Therapeutic bronchoscopy
Endocrinology	Thyroid aspiration biopsy

Subspecialty	Procedures that Must be Documented
Gastroenterology	1. Flexible sigmoidoscopy (colonoscopy may be substituted) 2. Diagnostic upper gastrointestinal endoscopy (EGD) 3. Colonoscopy, including biopsy and polypectomy 4. Esophageal dilation 5. Percutaneous gastrostomy 6. Therapeutic upper and lower gastrointestinal endoscopy, including variceal and non-variceal hemorrhage (The variceal and non-variceal could be separated out to make it 5 categories) Note: Liver biopsy is no longer a required procedure for gastroenterology programs.
Geriatric Medicine	No required procedures
Hematology	1. Bone Marrow aspirate and biopsy
Hematology/Oncology	1. Bone Marrow aspirate and biopsy
Oncology	1. Bone Marrow aspirate and biopsy
Infectious Diseases	No required procedures
Nephrology	1. Placement of temporary vascular access for hemodialysis and related procedures. 2. Percutaneous biopsy of autologous and native transplants.
Pulmonary Disease	1. Fiberoptic bronchoscopy procedures including those with: a. transbronchial biopsies b. bronchoalveolar lavage c. transbronchial needle aspiration d. bronchial biopsies 2. Chest tube insertion 3. Endotracheal intubation 4. Arterial Line insertion 5. Central venous line insertion 6. Pulmonary artery catheter insertion 7. Thoracentesis 8. Cardiopulmonary exercise testing
Pulmonary/Critical Care	1. Fiberoptic bronchoscopy procedures including those with: a. transbronchial biopsies b. bronchoalveolar lavage c. transbronchial needle aspiration d. bronchial biopsies 2. Chest tube insertion 3. Endotracheal intubation 4. Arterial Line insertion 5. Central venous line insertion 6. Pulmonary artery catheter insertion 7. Thoracentesis 8. Cardiopulmonary exercise testing
Sleep Medicine	No required procedures
Rheumatology	1. Diagnostic aspiration and/ or therapeutic injection of bursae, joints, entheses and tendon sheaths. 2. Analysis by light and compensated polarized light microscopy of synovial fluid.

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Appendix III

Faculty Qualifications Judged Acceptable by the Review Committee for Internal Medicine

Program Director, Associate Program Director(s),
Key Clinical Faculty, and Educational Coordinators

- **Core Internal Medicine Residency Programs**
- **Internal Medicine Subspecialty Fellowship Programs**

Review Committee for Internal Medicine Policy:
In core internal medicine programs, the Review Committee for Internal Medicine accepts only American Board of Internal Medicine (ABIM) certification qualifications for the program director (PD), the minimum number of required associate program director(s) (APD), the minimum number of required key clinical faculty (KCF), and the 11 education coordinators (EC).

In subspecialty internal medicine fellowship programs, the Review Committee for Internal Medicine accepts only ABIM certification qualifications for the program director (PD) and for the minimum number of required KCF.

The Review Committee for Internal Medicine does not accept equivalent qualifications for such faculty members, except in the following special cases for sleep medicine and geriatric medicine:

Geriatric Medicine
Geriatric Medicine KCF and Geriatric Educational Coordinator
Internal Medicine-Geriatric Medicine Fellowship Programs
Core Internal Medicine Residency Programs
The Review Committee for Internal Medicine will accept family medicine-educated faculty members with a current American Board of Family Medicine (ABFM) certification in geriatrics to serve as KCF members in geriatric medicine fellowship programs, or as Educational Coordinators (ECs), or as KCF members for geriatric medicine in core internal medicine residency programs.

Such faculty members must meet the following conditions:

1) The faculty members must have been educated in ACGME-accredited internal medicine-geriatric medicine fellowship, or a ACGME-accredited family medicine geriatric medicine fellowship.
2) The faculty members must maintain certification by the ABFM in family medicine and in geriatric medicine.
3) The faculty members must demonstrate to the core internal medicine residency program director or to the subspecialty geriatrics fellowship program director excellence in geriatric medicine education, as measured by faculty member evaluations by fellows.
4) In internal medicine-geriatric medicine fellowships, either the PD or the KCF must be ABIM-certified in geriatric medicine.

In addition, the Review Committee for Internal Medicine will allow family practice-educated

geriatricians with an ABIM or ABFM certification in geriatric medicine to act as admitting or teaching attendings on internal medicine-geriatric medicine inpatient or consultation services at the discretion of the program director.

Geriatric Medicine Program Director
–Internal Medicine-Geriatric Medicine Fellowship Programs

The Review Committee for Internal Medicine will accept a family medicine–educated faculty member with current ABFM certification in geriatric medicine to serve as a program director in an internal medicine-geriatric medicine fellowship program if he or she fulfills the following criteria:

1. Such candidates must fulfill the above-listed criteria for KCF
2. The candidate must have five years or more of experience as a geriatric medicine faculty member in an internal medicine residency or in an internal medicine-geriatric medicine fellowship.
3. The candidate must demonstrate the ability to establish and maintain an environment of inquiry and scholarship to the same degree as required for internal medicine subspecialty KCF members.
   - The candidate must be actively engaged in the scholarship of discovery or dissemination (see Program Requirement III.B.4.) as evidenced by at least three products of scholarship in any of the following categories in the past three years: peer-reviewed manuscripts, peer-reviewed grants, book chapters, review articles in peer-reviewed publications, or editorials in peer-reviewed publications.
   - Abstracts and presentations alone will not meet this requirement.
4. The candidate must be recommended by the core internal medicine residency program director for outstanding teaching and administrative ability.
5. The candidate must be approved by the Review Committee for Internal Medicine (see procedure below).

In addition, the exceptions to the program director credentials will be limited to internal medicine-geriatric medicine programs in departments of medicine with an accreditation history of substantial compliance with the Institutional Requirements and the Program Requirements for both core residencies and subspecialty fellowships in the most recent accreditation cycle.

There must be at least one internal medicine-certified KCF member or program director in a program granted an exception.

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