

1 **ACGME Program Requirements for Resident Education**
2 **In Internal Medicine**

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

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6 *Effective: July 1, 2009*

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8 **Introduction**

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10 Internal medicine is the discipline encompassing the study and practice of health promotion,
11 disease prevention, diagnosis, care, and treatment of men and women from adolescence to old
12 age, during health and all stages of illness. Intrinsic to the discipline are scientific knowledge,
13 the scientific method of problem solving, evidence-based decision making, a commitment to
14 lifelong learning, and an attitude of caring that is derived from humanistic and professional
15 values.

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17 **I. Institutions**

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19 **A. Sponsoring Institution**

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

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

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29 1. The sponsoring institution must:

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31 a) demonstrate that there is a culture of patient safety and
32 continuous quality improvement in the quality of patient care,
33 patient safety, and education. Systems and expertise must be
34 present at the institutional level to support, nurture, measure, and
35 enhance the quality of patient care and educational programs, and
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37 b) demonstrate a commitment to quality patient centered care and
38 safety, education, and scholarship sufficient to support the
39 residency program.
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41 c) establish the internal medicine residency within a department of
42 internal medicine;
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44 d) provide resident compensation and benefits, faculty, facilities, and
45 resources for patient centered clinical care, education, and
46 scholarship required for accreditation;
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48 e) designate and support a single program director within the internal
49 medicine administrative unit with the qualifications and appropriate
50 authority defined in Section IIA;

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- f) provide at least 50% salary support (at least 20 hours per week) for the program director;
- g) provide associate program directors (APD) based on program size. At a minimum, APDs are required at resident complements of 24 or greater according to the following parameters:

Residents	APDs
24-40	1
41-79	2
80-119	3
120-159	4
>159	5

- h) provide 20 hours per week salary support for each associate program director required to meet these program requirements;
- i) provide support for core faculty based on program size, according to the following faculty to resident ratio:

Residents	Core Faculty
<60	4
60-75	5
76-90	6
91-105	7
106-120	8
121-135	9
136-150	10
151-165	11
166-180	12
>180	13

- j) provide support for program administrator(s) and other support personnel required for operation of the program;
- k) assure notification of the Review Committee within 30 days of changes as outlined in the Institutional Requirements (III.B.10.a)-k);
- l) provide residents with access to training using simulation. That training must include, at a minimum, simulation of codes, medical emergencies and medical procedures; and,

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- m) provide access to an electronic health record. In the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development, and progress towards its implementation.
- 2. The sponsoring institution and participating sites must:
 - a) not place excessive reliance on residents to meet the service needs of the participating training sites.
 - b) provide the resources to ensure the implementation of the following:
 - (1) inpatient support services as specified in the Institutional Requirements must be present;
 - (2) inpatient and outpatient systems must be in place to prevent residents from performing routine clerical functions, such as scheduling tests and appointments, and retrieving records and letters;
 - (3) residents' service responsibilities must be limited to patients for whom the teaching service has diagnostic and therapeutic responsibility. (N.B.: Teaching Service is defined as those patients for whom internal medicine residents [PGY 1, 2, or 3] routinely provide care);
 - (4) residents must not be assigned more than one and a half months of night float during any year of training, or more than four months of night float over the three years of residency training. Residents must not be assigned to more than one month of consecutive night float rotation;
 - (5) for each rotation or major clinical assignment, there should not be so many learners that resident education is compromised;
 - (6) residents should not be required to relate to an excessive number of physicians of record;
 - (7) residents from other specialties must not supervise internal medicine residents on any internal medicine inpatient rotation;
 - (8) on inpatient rotations:
 - (a) a first-year resident must not be assigned more than five new patients per admitting day; an additional two patients may be assigned if they are in-house transfers from the medical services;

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- (b) a first-year resident must not be assigned more than eight new patients in a 48-hour period;
 - (c) a first-year resident must not be responsible for the ongoing care of more than 10 patients;
 - (d) when supervising more than one first-year resident, the supervising resident must not be responsible for the supervision or admission of more than 10 new patients and four transfer patients per admitting day or more than 16 new patients in a 48-hour period;
 - (e) when supervising one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 16 patients; and,
 - (f) when supervising more than one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 20 patients.
- (9) Residents must write all orders for patients under their care, with appropriate supervision by the attending physician. In those unusual circumstances when an attending physician or subspecialty resident writes an order on a resident's patient, the attending or subspecialty resident must communicate his or her action to the resident in a timely manner.
 - (10) Second- or third-year internal medicine residents or other appropriate supervisory physicians (e.g., subspecialty residents or attendings) with documented experience appropriate to the acuity, complexity, and severity of patient illness must be available at all times on site to supervise first-year residents.
 - (11) Each physician of record has the responsibility to make management rounds on his or her patients and to communicate effectively with the residents participating in the care of these patients at a frequency appropriate to the changing care needs of the patients.
 - (12) Total required transplant rotations in dedicated units should not exceed one month in three years.

195 **B. Participating Sites**

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

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The PLA should:

- a) identify the faculty who will assume both educational and supervisory responsibilities for residents;
- b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;
- c) specify the duration and content of the educational experience; and,
- d) state the policies and procedures that will govern resident education during the assignment.

- 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).

II. Program Personnel and Resources

A. Program Director

- 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 and
- 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.
- 3. Qualifications of the program director must include:
 - a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee,
 - (1) which includes at least five years of participation as an active faculty member in an ACGME-accredited internal medicine residency program, and
 - (2) at least three years of graduate medical education administrative experience prior to appointment.
 - b) current certification in Internal Medicine by the American Board of Internal Medicine, or specialty qualifications judged acceptable to the Review Committee;

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- (1) The Review Committee only accepts current Board certification.
- c) **current medical licensure and appropriate medical staff appointment**
- 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:**
 - a) **oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;**
 - b) **approve a local director at each participating site who is accountable for resident education;**
 - c) **approve the selection of program faculty as appropriate;**
 - d) **evaluate program faculty and approve the continued participation of program faculty based on evaluation;**
 - e) **monitor resident supervision at all participating sites.**
 - 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;**
 - g) **provide each resident with documented semiannual evaluation of performance with feedback;**
 - h) **ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;**
 - i) **provide verification of residency education for all residents, including those who leave the program prior to completion;**
 - 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:**
 - (1) **distribute these policies and procedures to the residents and faculty;**
 - (2) **monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;**

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- (3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,**
 - (4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.**
- k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;**
- l) comply with the sponsoring institution's written policies and procedures, including those specified the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;**
- m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;**
- n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:**
 - (1) all applications for ACGME accreditation of new programs;**
 - (2) changes in resident complement;**
 - (3) major changes in program structure or length of training;**
 - (4) progress reports requested by the Review Committee ;**
 - (5) responses to all proposed adverse actions;**
 - (6) requests for increases or any change to resident duty hours;**
 - (7) voluntary withdrawals of ACGME-accredited programs;**
 - (8) requests for appeal of an adverse action;**
 - (9) appeal presentations to a Board of Appeal or the ACGME; and,**
 - (10) proposals to ACGME for approval of innovative educational approaches.**

- 354 o) **obtain DIO review and co-signature on all program**
355 **information forms, as well as any correspondence or**
356 **document submitted to the ACGME that addresses:**
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358 (1) **program citations, and/or,**
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360 (2) **request for changes in the program that would have**
361 **significant impact, including financial, on the program**
362 **or institution;**
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364 p) dedicate no less than 50% (at least 20 hours per week) of his or
365 her professional effort to the administrative and educational
366 activities of the internal medicine educational program and receive
367 institutional support for this time;
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369 q) be available and accessible to residents at the primary teaching
370 site(s);
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372 r) ensure that departmental clinical quality improvement programs
373 are integrated in the organization of the educational program;
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375 s) oversee development of an effective resident advising program;
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377 t) supervise any internal medicine subspecialty training programs
378 sponsored by the institution to ensure compliance with the
379 ACGME accreditation standards;
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381 u) have supervisory authority over all educational tracks in the
382 internal medicine residency program;
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384 v) conduct the internal medicine component of special educational
385 tracks under the auspices of the Department of Internal Medicine;
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387 w) ensure that the residency does not place excessive reliance on
388 residents for service as opposed to education; and,
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390 x) participate in academic societies and in educational programs
391 designed to enhance his or her educational and administrative
392 skills.
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394 **B. Faculty**

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

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400 **The faculty must:**

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402 **a) devote sufficient time to the educational program to fulfill**
403 **their supervisory and teaching responsibilities; and to**

- 404 demonstrate a strong interest in the education of residents;
405 and,
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407 b) administer and maintain an educational environment
408 conducive to educating residents in each of the ACGME
409 competency areas.
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411 c) provide advising for residents in the areas of educational goal-
412 setting, career planning, patient care, and scholarship, and
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414 d) meet professional standards of behavior.
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416 2. The physician faculty must have current certification in the specialty
417 by the American Board of Internal Medicine, or possess qualifications
418 judged acceptable to the Review Committee.
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420 a) The Review Committee only accepts current Board certification.
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422 3. The physician faculty must possess current medical licensure and
423 appropriate medical staff appointment.
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425 4. The nonphysician faculty must have appropriate qualifications in
426 their field and hold appropriate institutional appointments.
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428 5. The faculty must establish and maintain an environment of inquiry
429 and scholarship with an active research component.
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431 a) The faculty must regularly participate in organized clinical
432 discussions, rounds, journal clubs, and conferences.
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434 b) Some members of the faculty should also demonstrate
435 scholarship by one or more of the following:
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437 (1) peer reviewed funding;
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439 (2) publication of original research or review articles in
440 peer reviewed journals, or chapters in textbooks;
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442 (3) publication or presentation of case reports or clinical
443 series at local, regional, or national professional and
444 scientific society meetings; or,
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446 (4) participation in national committees or educational
447 organizations.
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449 c) Faculty should encourage and support residents in scholarly
450 activities.
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452 6. Faculty members should participate in faculty development programs
453 designed to enhance the effectiveness of their teaching.
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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 the program.

1. Associate Program Directors

Associate program directors (APDs) are faculty who assist the program director in the administrative and clinical oversight of the educational program.

a) Qualifications of the associate program directors are as follows:

- (1) must be clinicians with broad knowledge of, experience with, and commitment to internal medicine as a discipline, patient centered care, and to the generalist training of residents, and .
- (2) must hold current certification from the American Board of Internal Medicine (ABIM).

b) Responsibilities for associate program directors are as follows:

- (1) must dedicate an average of at least 20 hours per week to the administrative and educational aspects of the educational program, as delegated by the program director, and receive institutional support for this time;
- (2) must report directly to the program director; and,
- (3) must participate in academic societies and in educational programs designed to enhance their educational and administrative skills.

2. Subspecialty Education Coordinators

In conjunction with division chiefs, the program director must identify a qualified individual, the Subspecialty Education Coordinator, in each of the following subspecialties of internal medicine: cardiology, critical care, endocrinology, hematology, gastroenterology, geriatric medicine, infectious diseases, nephrology, oncology, pulmonary disease, and rheumatology.

a) The Subspecialty Education Coordinator must be:

- (1) currently certified in the subspecialty by the ABIM, and
- (2) accountable to the program director for coordination of the residents' subspecialty educational experiences in order to accomplish the goals and objectives in the subspecialty.

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3. Core Faculty

The residency program must include institutionally-based core faculty in addition to the program director and associate program directors. The Core Faculty are the expert competency evaluators who work closely with the program director and associate program directors, who assist in developing and implementing the evaluation system, and who teach and advise residents. The Core faculty must:

- a) be ABIM-certified internists who are clinically active, either in direct patient care or in the supervision of patient care;
- b) dedicate an average of at least 15 hours per individual per week throughout the year to residency training;
- c) be specifically trained in the evaluation and assessment of the ACGME competencies;
- d) spend significant time in the evaluation of residents including the direct observation of residents with patients; and,
- e) advise residents with respect to their career and educational goals.

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.

- 1. The sponsoring institution must provide the broad range of facilities, medical staff, and clinical support service staff required to provide comprehensive care of adult patients. Residents must have clinical experiences in efficient, effective ambulatory and inpatient care settings.
- 2. Additional services must include those for: cardiac catheterization, bronchoscopy, gastrointestinal endoscopy, noninvasive cardiology studies, pulmonary function studies, hemodialysis, and imaging studies, including radionuclide, ultrasound, fluoroscopy, angiography, computerized tomography, and magnetic resonance imaging.
- 3. Adequate clinical and teaching space must be available, including meeting rooms, classrooms, examination rooms, computers, visual and other educational aids, and office space for teaching staff.
- 4. When residents are assigned duty in the hospital, the institution must provide them with:

- 557 a) on-call facilities that are convenient and that afford privacy, safety,
558 and a restful environment with a secure space for their
559 belongings, and
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561 b) sleeping rooms, lounge, and food facilities.
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563 5. Medical Records
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565 Refer to Institutional Requirements on medical records availability.
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567 6. Patient Population
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569 a) The patient population must have a variety of clinical problems
570 and stages of disease.
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572 b) There must be patients of both sexes, with a broad age range,
573 including geriatric patients.
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575 7. There must be services available from other health care professionals
576 such as nurses, social workers, case managers, language interpreters,
577 dieticians, etc. to assist with patient care.
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579 8. Consultations from other clinical services must be available in a timely
580 manner in all care settings where the residents work. All consultations
581 should be performed by or under the supervision of a qualified specialist.
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583 E. Medical Information Access

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585 **Residents must have ready access to specialty-specific and other**
586 **appropriate reference material in print or electronic format. Electronic**
587 **medical literature databases with search capabilities should be available.**
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589 III. Resident Appointment

590 A. Eligibility Criteria

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593 **The program director must comply with the criteria for resident eligibility**
594 **as specified in the Institutional Requirements.**
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596 B. Number of Residents

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598 **The program director may not appoint more residents than approved by the**
599 **Review Committee unless otherwise stated in the specialty specific**
600 **requirements. The program's educational resources must be adequate to**
601 **support the number of residents appointed to the program.**
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- 603 1. A program must have a minimum of 15 residents enrolled and
604 participating in the training program at all times.
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C. Resident Transfer

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.**
2. **A program director must provide timely verification of residency education and summative performance evaluation for residents who may leave the program prior to completion.**
3. A resident who has satisfactorily completed a preliminary training year should not be appointed to additional years as a preliminary resident.

D. Appointment of Fellows and Other Students

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

A. The curriculum must contain the following educational components:

1. **Overall educational goals for the program, which the program must distribute to residents and faculty annually;**
 - a) An accredited residency program in internal medicine must provide 36 months of supervised graduate medical education.
 - b) Residency training is primarily an educational experience in patient-centered care. The educational efforts of faculty and residents should enhance the quality of patient care, and the education of the residents. At least 1/3 of the residency training must occur in the ambulatory setting and at least 1/3 must occur in the inpatient setting. Emergency medicine cannot count toward the required 1/3 ambulatory or the 1/3 inpatient training time. (N.B.: See FAQ on method to calculate ambulatory percent).
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.**
 - a) For each rotation or major learning experience, the competency-based goals and objectives (the written curriculum) must contain

- 657 the educational plan, goals and objectives, educational methods,
658 and the evaluation tools that the program will use to assess the
659 resident's competence.
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- 661 b) The curriculum must ensure that each resident has sufficient
662 clinical exposure to the diagnostic and therapeutic methods of
663 each of the recognized internal medicine subspecialties.
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- 665 c) Educational venues and strategies.
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- 667 (1) Faculty with credentials appropriate to the care setting
668 must supervise all clinical experiences. These experiences
669 must include:
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- 671 (a) required critical care rotations (e.g., medical or
672 respiratory intensive care units, cardiac care units)
673 which cannot be fewer than three months and more
674 than six months over the 36 months of training;
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- 676 (b) exposure to each of the internal medicine
677 subspecialties and neurology;
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- 679 (c) an assignment in geriatric medicine;
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- 681 (d) opportunities for experience in psychiatry,
682 allergy/immunology, dermatology, medical
683 ophthalmology, office gynecology,
684 otorhinolaryngology, non-operative orthopedics,
685 and rehabilitation medicine;
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- 687 (e) opportunities to demonstrate competence in the
688 performance of procedures listed by the ABIM as
689 requiring only knowledge and interpretation;
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- 691 (f) a clinical experience in outpatient chronic disease
692 management, preventive health, patient counseling,
693 and common acute ambulatory problems. Overall
694 this experience must include an appropriate
695 distribution of patients of both genders and a
696 diversity of ages.
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- 698 (g) a longitudinal continuity experience in which
699 residents develop a continuous, long-term
700 therapeutic relationship with a panel of patients;
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- 702 (i) Programs must develop models and
703 schedules for ambulatory training that
704 minimize conflicting inpatient and outpatient
705 responsibilities.
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- 707 (ii) The longitudinal continuity experience:

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- (a) must include the resident serving as the primary physician for a panel of patients, with responsibility for chronic disease management, management of acute health problems, and preventive health care for their patients;
- (b) should not be interrupted by more than a month, not inclusive of vacation;
- (c) must include a minimum of 150 distinct half-day outpatient sessions devoted to longitudinal care of the resident's panel of patients extending at least over a 30 month period;
- (d) must include evaluation of performance data for each resident's continuity panel of patients relating to both chronic disease management and preventive healthcare. Residents must receive faculty guidance for developing a data-based action plan and evaluate this plan at least twice a year;
- (e) must include resident participation in coordination of care across healthcare settings. Residents should be accessible to participate in the management of their continuity panel of patients between outpatient visits. There must be systems of care to provide coverage of urgent problems when a resident is not readily available;
- (f) must include supervision by faculty who develop a longitudinal relationship with residents throughout the duration of their continuity experience;
- (g) must maintain a ratio of residents or other learners to faculty preceptors not to exceed 4:1;

- 759 (h) must have sufficient supervision and
760 teaching;
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762 (i) Faculty must not have other
763 patient care duties while
764 supervising more than two
765 residents or other learners,
766 and
767
768 (ii) Other faculty responsibilities
769 must not detract from the
770 supervision and teaching of
771 residents.
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773 (h) Internal medicine residents must be assigned to
774 emergency medicine for at least four weeks of
775 direct experience in blocks of not less than two
776 weeks.
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778 (i) Internal medicine residents assigned to
779 emergency medicine must have first-contact
780 responsibility for a sufficient number of
781 unselected patients to meet the educational
782 needs of internal medicine residents. Triage
783 by other physicians prior to this contact is
784 unacceptable
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786 (i) Total required emergency medicine experience
787 must not exceed two months in three years of
788 training.
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790 **3. Regularly scheduled didactic sessions;**
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- 792 a) The core curriculum must include a didactic program that is based
793 upon the core knowledge content of internal medicine.
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795 (1) The didactic program may include lectures, web-based
796 content, pod casts, etc. The program must afford each
797 resident an opportunity to review all of the core curriculum
798 topics.
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800 (2) Residents must have the opportunity to participate in
801 morning report, grand rounds, journal club, and morbidity
802 and mortality (or quality improvement) conferences, all of
803 which must involve faculty.
804
805 (3) The program must provide opportunities for residents to
806 interact with other residents and faculty in educational
807 sessions at a frequency sufficient for peer-peer and peer-
808 faculty interaction.
809

- 810 b) Patient based teaching must include direct interaction between
811 resident and attending, bedside teaching, discussion of
812 pathophysiology, and the use of current evidence in diagnostic
813 and therapeutic decisions. The teaching must be:
814
815 (1) formally conducted on all inpatient, outpatient and
816 consultative services, and
817
818 (2) conducted with a frequency and duration sufficient to
819 ensure a meaningful and continuous teaching relationship
820 between the assigned teaching attending and resident.
821

822 **4. Delineation of resident responsibilities for patient care, progressive**
823 **responsibility for patient management, and supervision of residents**
824 **over the continuum of the program; and,**
825

- 826 a) The program must ensure that over the course of the 36 months
827 each resident has increasing responsibility in patient care,
828 leadership, teaching, and administration.
829

830 **5. ACGME Competencies**
831

832 **The program must integrate the following ACGME competencies**
833 **into the curriculum:**
834

835 **a) Patient Care**
836

837 **Residents must be able to provide patient care that is**
838 **compassionate, appropriate, and effective for the treatment of**
839 **health problems and the promotion of health. Residents:**
840

- 841 (1) are expected to demonstrate the ability to manage
842 patients:
843
844 (a) in a variety of roles within a health system with
845 progressive responsibility to include serving as the
846 direct provider, the leader or member of a multi-
847 disciplinary team of providers, a consultant to other
848 physicians, and a teacher to the patient and other
849 physicians;
850
851 (b) in the prevention, counseling, detection, and
852 diagnosis and treatment of gender-specific
853 diseases;
854
855 (c) in a variety of healthcare settings to include the
856 inpatient ward, the critical care units, the
857 emergency setting and the ambulatory setting;
858
859 (d) across the spectrum of clinical disorders seen in
860 the practice of general internal medicine including

- 861 the subspecialties of internal medicine and non-
862 internal medicine specialties in both inpatient and
863 ambulatory settings;
864
865 (e) using clinical skills of interviewing and physical
866 examination;
867
868 (f) using the laboratory and imaging techniques
869 judiciously;
870
871 (g) by demonstrating competence in the performance
872 of procedures mandated by the ABIM; and,
873
874 (h) by caring for a sufficient number of undifferentiated
875 acutely and severely ill patients.
876
877 (2) must treat their patient's conditions with practices that are
878 safe, scientifically based, effective, efficient, timely, and
879 cost effective. The program must integrate patient centered
880 care and resident education. On all assignments, residents
881 and faculty interactions must be patient centered.
882

883 **b) Medical Knowledge**
884

885 **Residents must demonstrate knowledge of established and**
886 **evolving biomedical, clinical, epidemiological and social-**
887 **behavioral sciences, as well as the application of this**
888 **knowledge to patient care. Residents:**
889

- 890 (1) are expected to demonstrate a level of expertise in the
891 knowledge of those areas appropriate for an internal
892 medicine specialist, specifically
893
894 (a) knowledge of the broad spectrum of clinical
895 disorders seen in the practice of general internal
896 medicine.
897
898 (b) knowledge of the core content of general internal
899 medicine which includes the internal medicine
900 subspecialties, non-internal medicine specialties,
901 and relevant non-clinical topics at a level sufficient
902 to practice internal medicine
903
904 (2) are expected to demonstrate sufficient knowledge to
905
906 (a) Evaluate patients with an undiagnosed and
907 undifferentiated presentation
908
909 (b) Treat medical conditions commonly managed by
910 internists,
911

- 912 (c) Provide basic preventive care.
- 913
- 914 (d) Interpret basic clinical tests and images.
- 915
- 916 (e) Recognize and provide initial management of
- 917 emergency medical problems.
- 918
- 919 (f) Use common pharmacotherapy.
- 920
- 921 (g) Appropriately use and perform diagnostic and
- 922 therapeutic procedures.
- 923

924 **c) Practice-based Learning and Improvement**

925 **Residents must demonstrate the ability to investigate and**

926 **evaluate their care of patients, to appraise and assimilate**

927 **scientific evidence, and to continuously improve patient care**

928 **based on constant self-evaluation and life-long learning.**

929 **Residents are expected to develop skills and habits to be able**

930 **to meet the following goals:**

- 931
- 932
- 933 (1) identify strengths, deficiencies, and limits in one's
- 934 knowledge and expertise;
- 935
- 936 (2) set learning and improvement goals;
- 937
- 938 (3) identify and perform appropriate learning activities;
- 939
- 940 (4) systematically analyze practice, using quality
- 941 improvement methods, and implement changes with
- 942 the goal of practice improvement;
- 943
- 944 (5) incorporate formative evaluation feedback into daily
- 945 practice;
- 946
- 947 (6) locate, appraise, and assimilate evidence from
- 948 scientific studies related to their patients' health
- 949 problems;
- 950
- 951 (7) use information technology to optimize learning; and,
- 952
- 953 (8) participate in the education of patients, families,
- 954 students, residents and other health professionals.
- 955

956 **d) Interpersonal and Communication Skills**

957 **Residents must demonstrate interpersonal and**

958 **communication skills that result in the effective exchange of**

959 **information and collaboration with patients, their families,**

960 **and health professionals. Residents are expected to**

961 **demonstrate the ability to:**

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- (1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- (2) communicate effectively with physicians, other health professionals, and health related agencies;
- (3) work effectively as a member or leader of a health care team or other professional group;
- (4) act in a consultative role to other physicians and health professionals; and,
- (5) maintain comprehensive, timely, and legible medical records, if applicable.

e) Professionalism

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

- (1) compassion, integrity, and respect for others;
- (2) responsiveness to patient needs that supersedes self-interest;
- (3) respect for patient privacy and autonomy;
- (4) accountability to patients, society and the profession; and,
- (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.

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 demonstrate the ability to:

- (1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;

- 1013 (2) coordinate patient care within the health care system
1014 relevant to their clinical specialty;
1015
1016 (3) incorporate considerations of cost awareness and
1017 risk-benefit analysis in patient and/or population-
1018 based care as appropriate;
1019
1020 (4) advocate for quality patient care and optimal patient
1021 care systems;
1022
1023 (5) work in interprofessional teams to enhance patient
1024 safety and improve patient care quality; and,
1025
1026 (6) participate in identifying system errors and
1027 implementing potential systems solutions.
1028
1029 (7) work in teams and effectively transmit necessary clinical
1030 information to ensure safe and proper care of patients
1031 including the transition of care between settings; and,
1032
1033 (8) recognize and function effectively in high-quality care
1034 systems.
1035

1036 **B. Residents' Scholarly Activities**
1037

- 1038 1. The curriculum must advance residents' knowledge of the basic
1039 principles of research, including how research is conducted,
1040 evaluated, explained to patients, and applied to patient care.
1041
1042 2. Residents should participate in scholarly activity.
1043
1044 3. The sponsoring institution and program should allocate adequate
1045 educational resources to facilitate resident involvement in scholarly
1046 activities.
1047

1048 **V. Evaluation**
1049

1050 **A. Resident**
1051

1052 1. **Formative Evaluation**
1053

- 1054 a) The faculty must evaluate resident performance in a timely
1055 manner during each rotation or similar educational
1056 assignment, and document this evaluation at completion of
1057 the assignment.
1058

- 1059 (1) The faculty must discuss this evaluation with the resident
1060 at the completion of the assignment. Resident performance
1061 in continuity clinic must be reviewed with them verbally and
1062 in writing on at least a semiannual basis.
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b) The program must:

- (1) provide objective assessments of competence in addition to global assessment in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**

(a) Patient care:

The program must assess the resident in data gathering, clinical reasoning, patient management and procedures in both the inpatient and outpatient setting. This assessment must involve direct observation of resident-patient encounters.

(b) Medical knowledge:

The program must utilize an objective validated assessment method (e.g., in-service training examination, chart stimulated recall). The same assessment method must be administered at least twice during the training program.

(c) Practice-based learning and improvement:

The program must assess resident performance in:

- (i) application of evidence to patient care,
- (ii) practice improvement,
- (iii) teaching skills involving peers and patients, and
- (iv) scholarship.

Assessment of practice must include use of performance data.

(d) Interpersonal and communication skills:

The program must assess resident performance in the following:

- (i) communication with patient and family,
- (ii) teamwork,
- (iii) communication with peers, including transitions in care, and

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(iv) record keeping.

Assessment must include both direct observation and multi-source evaluation (including at least patients, peers and non-physician team members).

(e) Professionalism:

The program must assess the resident in the following:

(i) honesty and integrity,

(ii) ability to meet professional responsibilities,

(iii) ability to maintain appropriate professional relationships with patients and colleagues, and

(iv) commitment to self-improvement.

Assessment must include multi-source evaluation (including at least patients, peers, and non-physician team members).

(f) Systems-based practice:

The program must assess the resident in the following:

(i) care coordination, including transition of care,

(ii) ability to work in interdisciplinary teams,

(iii) advocacy for quality of care, and

(iv) ability to identify system problems and participate in improvement activities.

Assessment must include multi-source evaluation (including at least peers, and non-physician team members).

(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);

(3) document progressive resident performance improvement appropriate to educational level; and,

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(4) **provide each resident with documented semiannual evaluation of performance with feedback.**

c) **The evaluation of resident performance must be accessible for review by the residents, in accordance with institutional policy.**

d) **The record of evaluation must include a logbook or an equivalent method to demonstrate that each resident has achieved competence in the performance of invasive procedures.**

2. Summative Evaluation

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:

a) **document the resident's performance during the final period of education, and**

b) **verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.**

B. Faculty Evaluation

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

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

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

a) **In addition, residents must have the opportunity to provide confidential written evaluations of each teaching attending at the end of a rotation, and these evaluations must be reviewed annually with the attending.**

C. Program Evaluation and Improvement

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:**

a) **resident performance,**

- 1216 (1) including outcome assessment of the educational
1217 effectiveness of inpatient and ambulatory teaching.
1218
1219 **b) faculty development;**
1220
1221 **c) graduate performance, including performance of program**
1222 **graduates on the certification examination;**
1223
1224 (1) At least 80% of those completing their training in the
1225 program for the most recently defined three-year period
1226 must have taken the certifying examination.
1227
1228 (2) A program's graduates must achieve a pass rate on the
1229 certifying examination of the ABIM of at least 80% for first-
1230 time takers of the examination in the most recently defined
1231 three-year period.
1232
1233 **d) program quality. Specifically:**
1234
1235 (1) **Residents and faculty must have the opportunity to**
1236 **evaluate the program confidentially and in writing at**
1237 **least annually, and**
1238
1239 (2) **The program must use the results of residents'**
1240 **assessments of the program together with other**
1241 **program evaluation results to improve the program.**
1242
1243 e) the ability to retain qualified residents by graduating at least 80%
1244 of its entering categorical residents averaged over the most recent
1245 three-year period.
1246
1247 **2. If deficiencies are found, the program should prepare a written plan**
1248 **of action to document initiatives to improve performance in the**
1249 **areas listed in section V.C.1. The action plan should be reviewed**
1250 **and approved by the teaching faculty and documented in meeting**
1251 **minutes.**
1252
1253 3. The department should review and act on inpatient and outpatient
1254 performance data both in aggregate and for individual faculty members
1255 and share that information with the training program.
1256
1257 4. The program must organize representative program personnel (i.e., at
1258 least the program director, representative faculty, and one resident) to
1259 review program goals and objectives, and the effectiveness with which
1260 they are achieved..

1261 VI. Resident Duty Hours in the Learning and Working Environment

1263 A. Principles

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1. **The program must be committed to and be responsible for promoting patient safety and resident well being and to providing a supportive educational environment.**
2. **The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.**
3. **Didactic and clinical education must have priority in the allotment of residents' time and energy.**
4. **Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.**

B. Supervision of Residents

The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.

C. Fatigue

Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

D. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)

Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in house during call activities, and scheduled activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

1. **Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in house call activities.**
2. **Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.**
3. **Adequate time for rest and personal activities must be provided. This should consist of a 10 hour time period provided between all daily duty periods and after in house call.**
4. **During emergency medicine assignments, continuous duty must not exceed 12 hours.**

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E. On-Call Activities

- 1. In house call must occur no more frequently than every third night, averaged over a four-week period.**
 - a) Internal Medicine residency programs are not allowed to average in-house call over a four-week period.
- 2. Continuous on site duty, including in house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.**
- 3. No new patients may be accepted after 24 hours of continuous duty.**
- 4. At home call (or pager call)**
 - a) The frequency of at home call is not subject to the every third night, or 24+6 limitation. However at home-call must not be so frequent as to preclude rest and reasonable personal time for each resident.
 - b) Residents taking at home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.
 - c) When residents are called into the hospital from home, the hours residents spend in house are counted toward the 80 hour limit.

F. Moonlighting

- 1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.**
- 2. Internal moonlighting must be considered part of the 80 hour weekly limit on duty hours.**

G. Duty Hour Exceptions

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

- 1. In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.**
- 2. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.**

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- a) The Review Committee for Internal Medicine will not consider requests for exceptions to the limit to 80 hours per week, averaged monthly.

VII. Experimentation and Innovation

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

Effective July 1, 2009.