

Internal Medicine Residency Programs FAQ

Institutions		
Question	Answer	
How does the Review Committee interpret sufficient protected time and financial support for the program director? [Program Requirement I.A.]	<ul style="list-style-type: none"> It is important that the program director not be required to earn the portion of his/her salary devoted to program administration by clinical activity or research grants. The institution needs to work out the details of the source of this funding (sponsoring institution, hospital, department, etc.) and ensure that it happens. This applies to support for both program director and associate program directors. 	
We do not have a traditional/conventional department of medicine. Rather, we have a service line/institute/organization in which our internal medicine faculty and core internal medicine program are seated. Does this meet the program requirement? [Program Requirement I.A.1.a]	<ul style="list-style-type: none"> The sponsoring institution must establish an internal medicine residency program within a department of medicine or an administrative unit whose primary mission is the advancement of internal medicine resident education and patient care. (July 2011 RC Meeting) 	
Are co-program directors allowed? Program Requirement: I.A.1.b)	<ul style="list-style-type: none"> Co-directors are not accepted by the Review Committee, except for Medicine-Pediatrics programs. At all times, the single program director must have at least 50% salary support (at least 20 hours per week) dedicated to the residency program. 	
What types of activities demonstrate that there is a culture of and commitment to continuous quality improvement in the areas of patient care, patient safety and education? [Program Requirement I.A.2.a.-b.]	<p>The Review Committee believes that the fellows' educational experience/training needs to be conducted in an environment that emphasizes the importance of quality improvement in patient care, safety and education. There are a variety of activities that can be used to demonstrate that the sponsoring institution and participating site demonstrate a culture of and commitment to continuous quality improvement in the areas of patient care, patient safety and education exist in the training environment. Examples for patient care issues include, but are not limited to, processes evaluating the accuracy of inpatient and outpatient medication reconciliation, evaluating and improving adherence to infection control procedures, and improvement in communications between healthcare practitioners at all levels. Examples of commitment to scholarship include, but are not limited to, logistic support for onsite educational conferences, space for research activities, protected time for faculty and trainees to engage in scholastic activities and access to an institutional review board. The Review Committee will determine compliance to these program requirements by including in the program information forms the following questions which will be verified by the site visitor at the time of the program's site visit:</p> <ul style="list-style-type: none"> How does your institution monitor and improve the quality of care provided? Provide one example related to your subspecialty. How does your institution utilize quality measures to improve patient care or safety? Provide one example related to this subspecialty. How does your institution demonstrate a commitment to scholarship? Provide one example related to this subspecialty. 	
Can one individual fill the role of associate program director (APD) and core faculty (CF)? [Program Requirement: I.A.2.e)-g)]	<ul style="list-style-type: none"> No. One individual cannot fill the role of associate program director and core faculty member. The core faculty are really the faculty responsible for competency assessment and evaluation, while the associate program directors have much more of an administrative role in the program. Associate program directors assist the program director in residency program oversight and management and core faculty are the core evaluators. One individual cannot function as both associate program director and core faculty (even though associate program directors participate in the evaluation process and core faculty may have some administrative function), as the Review Committee expects separate individuals to perform these separate tasks. The Review Committee does allow associate program directors or core faculty to do double duty as education coordinators or as site coordinators. Calculation of associate program director and core faculty numbers is based on approved complement (the maximum number of residency "slots" for which program is approved), not numbers of residents on duty. 	
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	<table border="1"> <tr><td>APD</td><td>+</td><td>SEC</td><td>=</td><td>YES</td></tr> <tr><td>CF</td><td>+</td><td>SEC</td><td>=</td><td>YES</td></tr> <tr><td>SPD</td><td>+</td><td>SEC</td><td>=</td><td>YES</td></tr> <tr><td>APD</td><td>+</td><td>SD</td><td>=</td><td>YES</td></tr> <tr><td>APD</td><td>+</td><td>CF</td><td>=</td><td>NO</td></tr> <tr><td>M/P PD</td><td>+</td><td>APD</td><td>=</td><td>YES</td></tr> <tr><td>IM PD</td><td>+</td><td>SPD</td><td>=</td><td>NO</td></tr> <tr><td>SPD</td><td>+</td><td>APD</td><td>=</td><td>YES</td></tr> </table> <p> PD = Program Director APD = Internal Medicine Associate Program Director SEC = Subspecialty Education Coordinator CF = Core Faculty SPD = Subspecialty Program Director SD = Site Director IM PD = Internal Medicine Program Director M/P PD = Medicine/Pediatrics Program Director </p>	APD	+	SEC	=	YES	CF	+	SEC	=	YES	SPD	+	SEC	=	YES	APD	+	SD	=	YES	APD	+	CF	=	NO	M/P PD	+	APD	=	YES	IM PD	+	SPD	=	NO	SPD	+	APD	=	YES
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<p>What does the Review Committee consider as part of the range of simulation? [Program Requirement I.A.2.j)]</p>	<ul style="list-style-type: none"> 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 OSCEs, standardized patients, patient simulators, or electronic simulation of codes, procedures, and other clinical scenarios. 																																								
<p>What does the Review Committee consider as examples of electronic medical records? [Program Requirement I.A.2.k)]</p>	<ul style="list-style-type: none"> Residents must have access to an electronic health record (EHR). 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 training sites and does not have to be comprehensive. A system that simply reports lab results or radiology results does not meet this definition of an EHR. 																																								
<p>How can programs minimize "conflict" between inpatient and outpatient rotations? [Program Requirement I.A.2.m)(2)]</p>	<ul style="list-style-type: none"> This requirement was written to encourage programs to be innovative in balancing the inherent conflicts between inpatient and outpatient responsibilities. Methods for doing this include, but are not limited to: having an effective handoff process and responsible team member to cover the inpatient service when residents are in their clinics; scheduling blocks with increased continuity clinic when residents are not on inpatient rotations, so that they can have less or no clinic during their inpatient rotations; handling outpatient issues by a member of a resident "firm system" when other members of the team are on busy inpatient rotations. There will be a question on the Resident Survey that addresses this issue and it will be verified at the time of a site visit. 																																								
<p>Is there a cap on night float admissions? [Program Requirement: I.A.2.m).(4)]</p>	<ul style="list-style-type: none"> Yes. The program requirements set an admission cap for interns at no more than 5 admissions per 24 hours. In the judgment of the Review Committee, this is the maximum number of new patients that a PGY-1 resident can consistently admit, evaluate thoroughly, and care for safely in a 24 hour period and still have sufficient time for education. The Review Committee would not approve an increase in the cap simply because the intern was on a night float rotation and would be turning the care of these patients over to a colleague. However, the Review Committee does not apply the 8 in 48 rule to night floats. In other words, on a night float week (= up to 6 days), an intern night float could admit up to 5 patients each night, and a PGY-2/3 night float could admit up to 10 patients each night. 																																								
<p>What does the Review Committee for Internal Medicine consider to be "night medicine" and how does it relate to "night float"? [Program Requirement: I.A.2.m)(4)]</p>	<p>"Night medicine" is defined as a rotation of two or more consecutive nights of inpatient clinical duty which includes the following:</p> <ul style="list-style-type: none"> Faculty interaction that allows for meaningful evaluation of resident performance, including the opportunity for bedside teaching and observation of direct patient care; Interaction with the patient's primary daytime physicians; 																																								

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	<ul style="list-style-type: none"> • A predefined cohort of patients for which the resident is responsible; • Input into the ongoing care of the patient during his/her hospitalization; • A defined curriculum with goals and objectives; and accessibility of consultants (in person or by phone). <p>This applies to all hospital inpatient floor rotations. Emergency department rotations are not included. If these criteria are met for night duty on ICU rotations, then the night duty counts towards ICU time and not towards “night medicine.”</p> <p>The annual and total limits of “night float” as specified in the program requirements will not change: “night float” must not exceed two months per year nor more than four months across the three years of residency. However, programs can extend the sum of “night float” and “night medicine” to five months over the three year residency.</p> <p>Programs are encouraged to incorporate the criteria mentioned above for “night medicine” into all night duty experiences. (May 2011 RC Meeting)</p>
<p>What does the Review Committee consider excess physicians of record? [Program Requirement: I.A.2.m).(6)]</p>	<ul style="list-style-type: none"> • The Review Committee will cite a program if a PGY-1 (intern) routinely must relate to <u>more than six (6)</u> physicians-of-record concurrently. However the Review Committee will also cite a program if it is apparent the intern or resident has difficulty communicating or learning from the physicians of record, even if it is less than six (6).
<p>When patients are admitted from our Night Float team and then “turned over” the following day to the ward team, do those patients count toward the intern “new patient in an admitting day” cap? [Program Requirement: I.A.2.m).(8).(a)]</p>	<ul style="list-style-type: none"> • Up to two transfer patients from night float can be counted as transfers (i.e., “+2 patients”); additional transfers “count” as new patients. For the senior, 4 can be counted as transfers and any others are counted as new patients.
<p>How does the Review Committee count admissions to the intern, resident, and team if the call period is less than 24 hours? [Program Requirement: I.A.2.m).(8).(a)]</p>	<ul style="list-style-type: none"> • Each call period must be for a maximum of 24 hour, but can be less. During this call period, each intern can admit up to 5 patients and two transfers from the medical services. The supervising resident can supervise or admit a maximum of 10 new patients and 4 transfer patients.
<p>How does the Review Committee define <u>transfer</u> patients? [Program Requirement: I.A.2.m).(8).(a)]</p>	<ul style="list-style-type: none"> • The Review Committee defines transfer patients as (1) transfers from the night float team, or transfers from other medical services, e.g. out of the CCU or MICU, and (2) bounce-back admissions within the same rotation month.
<p>How many <u>consults</u> are allowed in the cap? [Program Requirement: I.A.2.m).(8).(a)]</p>	<ul style="list-style-type: none"> • Consults are not admissions. There are no program requirements for consult numbers. If residents were required to perform an excessive numbers of consults, this would be cited as service versus education related issues. The Review Committee would examine very carefully any instance where interns or residents were expected to complete consultations in addition to inpatient admitting responsibilities.
<p>If an admitting resident supervises only one intern, can that supervising resident admit patients on their own? [Program Requirement: I.A.2.m).(8).(d)]</p>	<ul style="list-style-type: none"> • Yes. The supervising resident may supervise or admit a maximum of 10 new patients in an admitting day. In other words, the resident may supervise 5 intern admissions and admit another 5 patients without the intern. The supervising resident may also supervise or admit up to four additional “transfer patients.”
<p>How many patients can be cared for by a team with one resident and a hospitalist? [Program Requirement: I.A.2.m).(8).(d)]</p>	<ul style="list-style-type: none"> • The Review Committee believes it is neither necessary nor feasible to set explicit admission and census caps for every conceivable variation in the composition of the patient care team (intern only, resident with acting intern, resident with intern and NP, etc). In assessing the appropriateness of patient load for non-traditional teams, the Review Committee will consider work hours and resident-reported service-education balance.
<p>Program Personnel and Resources</p>	
Question	Answer
<p>Does the Review Committee grant waivers for the 5-year faculty or</p>	<ul style="list-style-type: none"> • No. The Review Committee feels strongly that 5 years as internal medicine faculty and 3 years of GME experience is an important

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<p>the 3-year administrative experience requirement for program director qualifications? [Program Requirement: II.A.3.a).(1)]</p>	<p>prerequisite for the responsibilities listed for the program director. As such, waivers for these program requirements are not granted.</p> <ul style="list-style-type: none"> • The Review Committee requires the program director of an internal medicine program to have at least 5 years experience as a faculty in a teaching hospital, and at least three years experience in residency administration (e.g., as an associate program director, as a core faculty, education coordinator, or the equivalent in internal medicine core residency or subspecialty fellowship). • This experience does not include time spent in fellowship training, but Chief Residency “counts” if it was a 4th-year position with junior faculty responsibilities.
<p>Does the Review Committee grant waivers for ABIM certification of the program director, if we can demonstrate “equivalent credentials?” [Program Requirement: II.A.3.b)]</p>	<p>No. Only ABIM certification is acceptable; no other credentials are accepted. The Review Committee uses ABIM certification as one of its major outcome measures. Furthermore, the ABIM publicly publishes program pass rates, and individual certification status. A major goal and outcome of each internal medicine core (and subspecialty) training program has been the training of ABIM-certified graduates. ABIM-certified program director (and core faculty, associate program director, education coordinator) demonstrate to the trainees the value and importance of ABIM certification. Note that the ABIM now has a pathway for certification of faculty who were not trained in an ACGME-accredited program. The Review Committee will withhold accreditation of applications that are not led by ABIM-certified internists.</p> <p>The Review Committee standard for program director certification is as follows:</p> <ul style="list-style-type: none"> • The core internal medicine program director must be ABIM-certified, and must maintain certification in general internal medicine. • The core internal medicine program director cannot let core certification lapse and maintain only subspecialty certificate (this is acceptable for the program director of a subspecialty program).
<p>What is the program director expected to do in order to educate the residents in the ACGME competencies? [Program Requirement: II.A.4.]</p> <p>What is the program director expected to do in order to achieve objective assessment of residents? [Program Requirement: V.A.1.b)(1)]</p>	<p>At a minimum, the Review Committee expects the program director to provide the following for in order to educate the residents in the ACGME competencies:</p> <ul style="list-style-type: none"> • Competency-based Curriculum • Resident awareness of competencies and outcomes • Faculty awareness of competencies and outcomes <p>At a minimum, the Review Committee expects the program director to do the following to achieve objective assessment of residents:</p> <ul style="list-style-type: none"> • Competency-based Semi-Annual Reviews • Competency-based Global Ratings • Competency-based Advancement Criteria • Procedure Logs • Multi-Source (360) Evaluations (At least three: patients, peers, nurses, other health care personnel, self) • Competency-based Summative Evaluations • Educational activities and experiences appropriate to specific Competencies • Evaluation methods appropriate to specific Competencies, as specified in Section V.A.1. b).
<p>Individual divisions make teaching faculty assignments at our hospital. Why does the Review Committee suggest that the program director select these faculty members? [Program Requirement: II.A.4.c)]</p>	<ul style="list-style-type: none"> • The Review Committee considers control of faculty, resident assignments, and all other aspects of the residency program to be the central role of the residency program director. • The Review Committee expects and requires that the program director have the authority to remove selected faculty from teaching assignments based on resident evaluations of the faculty. • The program director must also have the authority to deny faculty admitting privileges to the teaching service, based on resident evaluations of the faculty. • The program director must have the authority to make all resident assignments, and to remove residents from services judged by the program director to have insufficient educational value. • The program director must exercise this authority when the need arises (e.g., residents complain about a faculty member).

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	<ul style="list-style-type: none"> The execution of this authority can be shared (e.g., with the department chair) as long as the end-result is the same. It is also acceptable for a departmental representative to make teaching assignments, as long as the program director has the authority and ability to override the assignments (to select or deselect faculty).
Can a non-internist serve as a faculty preceptor in continuity clinic? [Program Requirement: II.A.4.c)]	<ul style="list-style-type: none"> The Review Committee allows the program director, under rare circumstances, to appoint an experienced non-internist with special expertise to supervise in ambulatory setting (e.g. a family medicine physician with extensive ambulatory experience, procedural or other pertinent training). It is expected that the site director for each continuity clinic be an internist and the vast majority of preceptors be internists.
What program changes do not require Review Committee approval? [Program Requirement: II.A.4.n).(2)]	<p>The following changes do not require approval by the Review Committee:</p> <ul style="list-style-type: none"> Individual variations in training (e.g., parental leave, medical LOA) Individual interruptions in training that are not part of an established track (e.g., an individual resident obtaining an MPH or PhD between years 1 and 3) Residents who undertake additional years of training (e.g., extra year of research), because they do not count against the complement.
If we have a resident with delayed completion due to pregnancy leading to a temporary situation where we exceed the number of approved resident for two months, is Review Committee notification required? [Program Requirement: II.A.4.o).(2)]	<ul style="list-style-type: none"> Yes. Even temporary increases, greater than or equal to one month, in the approved maximum number of residents (the "resident complement") require notification of, and approval by, the Review Committee. Notification and approval is relatively easy, through the WebADS system.
Why does the Review Committee list the program director time as both 50% and 20 hours/week? Does the Review Committee stipulate how this time should be spent? [Program Requirement: II.A.4.q)]	<ul style="list-style-type: none"> The Review Committee stipulates both percent time and hours per week in order to underscore the importance of administrative time for the program director. All activities that involve residents or the program "count." The program director must have sufficient time for administration of the program.
Does the ACGME expect the program director of the internal medicine residency to be responsible for the subspecialties too? [Program Requirement: II.A.4.u)]	<ul style="list-style-type: none"> Yes. The Review Committee considers the core program director to be ultimately responsible for all accredited internal medicine residency and fellowship training at each institution. There must be a reporting relationship from subspecialty program director to the core program director.
Can fellows act as faculty at some sites? [Program Requirement: II.B.1.]	<ul style="list-style-type: none"> Fellows may function as attending physicians in very limited circumstances outside their accredited training: (e.g., a fellow moonlighting as a hospitalist at night in their own institution, after completing fellowship duties for that day, and staying within the duty hour regulations).
What is the minimum standard for compliance with the scholarly activity requirements in core internal medicine residency programs? [Program Requirement: II.B.5.]	<ul style="list-style-type: none"> At least 50% of residents and faculty must participate in the scholarship of discovery (as evidenced by peer reviewed funding or by publication of original research in a peer reviewed journal), dissemination (as evidenced by review articles or chapters in textbooks), or application (as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings; or must present scholarly discussions (journal club, grand rounds, etc.). Note that there exists a higher standard for subspecialties.
What are ABIM certification requirements for associate program directors (APD), core faculty (CF), and education coordinators (EC)? [Program Requirement: II.C.1.a).(2)]	<ul style="list-style-type: none"> The Review Committee accepts no equivalent credentials except ABIM certification for the minimum required number of associate program directors, core faculty, and education coordinators. Only ABIM-certification meets these requirements (except for geriatrics). The ABIM now has a pathway for faculty trained outside the United States to apply for ABIM Certification after 8 years on the faculty. Associate program directors, core faculty, and education coordinators may be subspecialty re-certified only (i.e., allow core internal medicine to lapse). HOWEVER, faculty who allow core internal medicine to lapse will not be eligible to become program director unless core internal medicine certification renewed.
What activities can be counted the	<ul style="list-style-type: none"> All activities that involve residents or the program can be counted towards

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20 hours per week required for an associate program director? [Program Requirement: II.C.1.b).(1)]	the 20 hours a week required of an associate program director.
What are the responsibilities for the subspecialty education coordinators (EC)? [Program Requirement: II.C.2.]	<ul style="list-style-type: none"> • The program requirements stipulate that there be an ABIM-subspecialty certified education coordinator (EC) for each of the identified subspecialties responsible for resident education in the internal medicine specialties. • The education coordinator has oversight for a specific educational content area, although a core faculty can also function as an education coordinator with adequate additional administrative resources. • The Review Committee expects that each education coordinator fulfill the Program Requirements that require the education coordinator to: "be accountable to the program director for coordination of the residents' subspecialty educational experiences in order to accomplish the goals and objectives in the subspecialty." • The Review Committee expects that each education coordinator will have a direct reporting responsibility to the program director, and sufficient administrative time to develop and implement the subspecialty curriculum and subspecialty educational experience(s). • There must be one certified education coordinator for each subspecialty, but double-boarded education coordinators can act as education coordinators for two specialties (e.g., hematology-oncology, pulmonary-critical care, and family medicine geriatrics).
Can an education coordinator serve as a core faculty, associate program director, or subspecialty program director? [Program Requirement: II.C.2.]	<ul style="list-style-type: none"> • Yes. A subspecialty education coordinator can serve as a core faculty member, associate program director, or subspecialty program director. (see table on page 1)
What is acceptable training for core faculty who will serve as competency evaluators? [Program Requirement II.C.3. – II.C.3.d)]	<ul style="list-style-type: none"> • The requirements now require an identified group of core faculty, based on the size of the program. An important role for these faculty is to serve as competency evaluators for the program. As described in the requirements, these faculty must be specifically trained in the evaluation and assessment of the ACGME competencies. This can be achieved through participation in workshops offered through APDIM, the ABIM, or the ACGME, or through local GME faculty development programs that focus on competency assessment. The evaluators must have ongoing training in these areas. The program should be able to document that the evaluators have been active in the assessment of residents.
Can a faculty member who is ABIM-certified in their subspecialty but not in core Internal Medicine serve as core faculty? [Program Requirement: II.C.3.a)]	<ul style="list-style-type: none"> • Yes, provided that s/he maintains certification in the subspecialty.
What facilities are necessary in call rooms? [Program Requirement: II.D.4.a)]	<ul style="list-style-type: none"> • A call room must be available for each resident who is required to stay in hospital for in-house, overnight call. • Residents may share a call room if it ensures a private, safe, and restful environment. Ordinarily, this means gender-specific, shared call space, with locks or lockers. • If a resident on home call is required to (or finds it necessary to) sleep in the hospital when called in from home, a call room must be available. • Residents must have access to restrooms and showers in close proximity to call rooms. • Residents on call should have access to computers either in or in close proximity to call rooms.
Are vending machines an acceptable food facility? [Program Requirement: II.D.4.b)]	<ul style="list-style-type: none"> • Yes, vending machines may be acceptable after hours as long as healthy options are available.
Resident Appointments	
Question	Answer
After completing a preliminary year in internal medicine, what are the options? Can a resident be appointed to another preliminary	<ul style="list-style-type: none"> • No, a resident cannot be appointed to an additional preliminary year in internal medicine. After completing a preliminary year, a resident may be appointed to an internal medicine residency program only in a categorical position. They can be appointed to either a PGY-1 or PGY-2 categorical

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year? [Program Requirement III.C.3.]	position based on their aptitude as judged by the program director. This can even be mixed and matched (e.g., 6 months as a categorical intern and then advance to PGY-2).
At times, our MICU rotation has more than 8 learners with one attending on rounds. The learners are students and residents. A PharmD faculty member rounds with this team and provides instruction on pharmacological issues. Does this non-physician faculty count as an attending physician? [Program Requirement: III.D.]	<ul style="list-style-type: none"> • The purpose of this program requirement is to prevent situations in which the number of learners is so large that the teaching attending cannot adequately supervise and teach each learner. For that reason, programs with services that assign more than 8 learners per teaching attending will be cited. • Certain participants on rounds (e.g., fellows, pharmacists, etc.) do not “count” towards the 8 if their presence is primarily for resident/ student education, AND the attending is not responsible for their education. • This requirement is not intended for assignment of multiple attendings to teams with more than 8 learners. Instead, it is designed to place limits on team size in order to preserve the educational environment, bedside teaching, and faculty familiarity with learners. Therefore, a program will be cited for 2 attendings on a team with 9 or more learners.
Educational Program	
Question	Answer
What is considered the minimum requirement for subspecialty experience? [Program Requirement: IV.A.2.b)]	<ul style="list-style-type: none"> • All residents must have “sufficient” clinical experiences in each of the subspecialties of internal medicine. For each specialty there must be: a curriculum, a subspecialty coordinator, and “sufficient clinical exposure to the diagnostic and therapeutic methods of each of the recognized internal medicine subspecialties.” The Review Committee will examine the PGY-3 responses on the resident survey and the site visitor’s report to verify the adequacy of this training.
Can nurse practitioners or physician assistants supervise Medicine residents or fellows on inpatient rotations? [Program Requirement IV.A.2.c)(1)] [Program Requirement VI.B]	<ul style="list-style-type: none"> • Although the Review Committee believes that it is important for internal medicine residents and fellows to acquire experience in leading and participating in healthcare teams including those with non physicians (e.g.: nurse practitioners or physician assistants), overall supervision of all clinical care rendered by residents and fellows is the responsibility of the physician faculty and the attending physician of record. Non physicians are not permitted to independently supervise internal medicine residents and fellows on inpatient rotations. Nevertheless, the attending physician may delegate an appropriately qualified non physician to assist a resident or fellow in performing a procedure. However, the ultimate responsibility for supervision remains the responsibility of the attending physician.
Can a non-internist (e.g., Family Practitioner or Neurologist) be the attending of record or the teaching attending for patients on an inpatient internal medicine teaching service? [Program Requirement: IV.A.2.c).(1)]	<ul style="list-style-type: none"> • The Review Committee expects that attendings on inpatient internal medicine teaching services to be internists to fulfill this program requirement. A non-internist may not serve as the attending of record or teaching attending on any internal medicine teaching service except under the following circumstances: • The Review Committee will prospectively examine exceptions (variances) to this policy for only neurology attendings when the program has a unique educational rationale. For instance: a program may demonstrate that the appointment of (a) specific neurologist(s) as the teaching attending for neurology inpatients admitted to an internal medicine teaching service provides a unique educational experience in neurology. The program director remains responsible for selecting the neurologist(s) for this teaching assignment, for evaluating their teaching effectiveness, and for monitoring the patient volumes and clinical education to ensure that all residents receive sufficient education in neurology; • The Review Committee will allow family medicine trained geriatricians with an ABIM or ABFM certification in geriatrics to act as admitting or teaching attendings on internal medicine geriatrics inpatient or consultation services at the discretion of the program director. • When non-internal medicine patients are admitted to an internal medicine teaching service, the Review Committee expects the attending of record to be an internist (typically the service attending or teaching attending). However, the admitting non-internist can continue to serve as a consultant for the patient’s specialty care. • On non-internal medicine services, other specialists are appropriate as teaching attendings. On all rotations, the program director must insure that the assignment has goals and objectives, evaluation, and adequate supervision. • Programs are also cited if residents complain about lack of faculty

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	expertise and competence.
Can a faculty member board-certified in Anesthesia or Surgical Critical Care Medicine by the ABMS or board-certified in Critical Care Medicine by the American Osteopathic Association supervise Medicine house staff in the Critical Care Units? [Program Requirement IV.A.2.c)(1)(a)]	<ul style="list-style-type: none"> No. The Review Committee does not approve of, or accept non-ACGME trained internists or non-ABIM certified physicians serving as teaching attendings or attendings-of-record on inpatient internal medicine services including the medical critical care units. This includes cross-coverage by other attendings for the attending-of-record on nights, weekends and holidays. However, this does not preclude non-ABIM certified intensivists from supervising medicine residents and fellows taking elective or required rotations in non-medical intensive care units. It also does not preclude consultation by these individuals if required for patient care or for procedural supervision.
Can an osteopathic physician serve as an attending of record or a teaching attending on an internal medicine teaching service? [Program Requirement IV.A.2.c)(1)(a)]	<ul style="list-style-type: none"> Yes, only if s/he has completed an ACGME-accredited internal medicine residency.
Will the Review Committee allow a family medicine trained geriatrician to teach internal medicine residents? [Program Requirement IV.A.2.c)(1)(a)]	<ul style="list-style-type: none"> The Review Committee will accept family medicine trained faculty with current certification in geriatrics from the ABFM to serve as an education coordinator (EC) for geriatrics in internal medicine core residency programs. Such faculty must meet the following conditions: <ul style="list-style-type: none"> The faculty must be trained in an ACGME-accredited Internal medicine geriatrics fellowship, or a family medicine geriatrics fellowship. The faculty must maintain certification by the ABFM in family medicine and certification in geriatric medicine. The faculty must demonstrate to the core internal medicine residency director excellence in geriatrics education, as measured by their faculty evaluations by residents. In addition, the Review Committee will allow family medicine trained and certified geriatricians to act as the admitting or teaching attending on internal medicine geriatrics inpatient or consultation services at the discretion of the program director.
What certification is considered acceptable to direct a critical care unit? [Program Requirement IV.A.2.c)(1)(a)]	<ul style="list-style-type: none"> An ABMS-certified critical care specialist must be the director of a combined MICU-SICU unit. An ABIM-certified critical care specialist must be the director of a MICU-CCU unit or a MICU unit. An ABIM-certified cardiologist should be the director of the CCU.
Do all residents need to rotate on a neurology service? [Program Requirement: IV.A.2.c).(1).(b)]	<ul style="list-style-type: none"> While a neurology rotation is not mandated in the requirements, the Review Committee will examine very carefully programs that propose to meet the standard without a dedicated rotation. The program must provide residents with instruction and sufficient clinical experience in neurology to acquire the knowledge needed to diagnose, follow, and treat patients with common neurologic disorders and to recognize those disorders that should be referred to a neurologist.
What does the Review Committee consider to be an adequate geriatrics experience? [Program Requirement: IV.A.2.c).(1).(c)]	<ul style="list-style-type: none"> Each resident must have a rotation in geriatrics. Although the Review Committee does not specify the length of the rotation, experiences of less than one month will be examined very carefully. At a minimum, each program must have at least one ABIM-certified (or ABFM) geriatrician directing the rotation and responsible for the curriculum. Each attending need not have a board certification in geriatric medicine.
Are goals and objectives and a written curriculum required for all elective clinical experiences designated as opportunities (i.e., psychiatry, allergy/immunology, dermatology, medical ophthalmology, office gynecology, otorhinolaryngology, non-operative orthopedics, palliative medicine, sleep medicine, and rehabilitation medicine)? [Program Requirement:	<ul style="list-style-type: none"> No. However, if written goals and objectives for the experience are not in place, then each resident who elects one of these clinical experiences should have a personalized learning plan. This plan should include goals and objectives mutually agreed upon by the resident and supervising faculty, it should be included in the resident's file, and should include an assessment by the resident at the end of the rotation whether the resident's goals and objectives were met.

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IV.A.2.c).(1).(d)]	
<p>If a resident desires the opportunity to perform procedures other than those required by the ABIM, what is program's responsibility? [Program Requirement: IV.A.2.c).(1).(e)]</p>	<ul style="list-style-type: none"> The Review Committee requires programs to offer opportunities for residents to obtain experience for those procedures that the ABIM requires knowledge competency only, as appropriate for the resident's future practice. Programs should include a review of procedural competence at the semi-annual reviews in order to identify those procedures for which additional individualized training is necessary.
<p>Can a Department of Veterans Affairs-(VA) Women's Health Primary Care (WH-PC) clinics serve as a part of the required (30 months, 130 sessions) longitudinal continuity experience if (in order to assure gender diversity), the WH-PC clinic is combined with a VA primary care clinic at the same site? [IV.A.2.c).(1).(f) – IV.A.2.c).(1).(g).(ii).(a) – (d)]</p>	<p>At present, programs with WH-PC clinics can include them as a part of the required 33% ambulatory experience, either as block or continuity experiences – i.e., a WH-PC experience may be <i>in addition to</i> the principal continuity clinic and count as part of the requirement that the ambulatory experience must be at least 33% of the training and have a patient mix with at least 25% of each gender. However, to qualify as part of <u>the</u> longitudinal continuity experience in which residents develop a continuous, long-term therapeutic relationship with a panel of general internal medicine patients (occurring for at least 130 session over 30 months of training), the program would need to request a waiver to the requirement that the continuity clinic experience takes place at a single site. Here is the link to the waiver form that needs to be completed: http://www.acgme.org/acWebsite/navpages/nav_program_experimentation.asp</p> <p>This request would need to include a detailed description of the continuity experience, including the WH-PC experience, and specifically address how the WH-PC experience will:</p> <ol style="list-style-type: none"> Allow residents to develop a continuous, long-term therapeutic relationship with a panel of general internal medicine patients in the WH-PC. Not have interruptions of more than one month for each resident. Allow the resident to address chronic disease, prevention, and acute care in his/her WH-PC panel. Allow the resident to coordinate care for his/her WH-PC panel of patients across care settings and for urgent problems. Allow the resident to obtain and evaluate performance data for his/her patients in the WH-PC. Assure the resident has a long-term relationship with supervising faculty in the WH-PC.
<p>How will the Review Committee assess gender diversity? [Program Requirement IV.A.2.c).(1).(f)]</p>	<ul style="list-style-type: none"> At the time of a site visit, the Review Committee will examine data related to gender diversity across the ambulatory portion of the training. It expected that residents will have a minimum of 25% of patients of each gender.
<p>Can continuity clinic occur only at the VA? [Program Requirement IV.A.2.c).(1).(f)]</p>	<ul style="list-style-type: none"> Yes. Continuity clinic may occur only at the VA but the entire ambulatory portion of the training (including the continuity clinic) for each resident must include at least 25% of patients of each gender.
<p>Can residents change clinics during residency? [Program Requirement: IV.A.2.c).(1).(g)]</p>	<ul style="list-style-type: none"> No. The Review Committee expects that residents will follow a panel of patients for the duration of the 36-month residency. Patients should consider the resident "their" primary-care doctor, and the residents should consider the continuity clinic patients to be "their" patients. While new patients will be added to the panel (and others leave) throughout residency, the Review Committee expects that the resident will not change clinics during the 36 months in order to maintain continuity for this patient panel. Residents may add a second clinic in the PGY-2 year, but cannot switch clinics in order to diversify experiences.
<p>How should programs count the 30-month period? [Program Requirement IV.A.2.c).(1).(g).(ii).(b)]</p>	<ul style="list-style-type: none"> The 30-month time frame was established to assure a minimum duration of time in which residents would provide care to their panel of patients while allowing flexibility for programs. The time begins when the resident sees a patient of his/her practice and ends 30 months later. The clinic does not have to occur weekly to allow for flexibility in scheduling. However, the longitudinal experience cannot be interrupted by more than a month, not inclusive of vacation.
<p>How does the Review Committee define 130 continuity clinic sessions?</p>	<ul style="list-style-type: none"> The 130 continuity clinic sessions should be distinct half-day sessions in which the residents provide longitudinal care to their panel of patients. This will occur in a single setting. Time spent in this clinical setting in

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<p>[Program Requirement IV.A.2.c).(1).(g).(ii).(c)]</p>	<p>which the resident does not provide care to their panel of patients does not count toward the 130 sessions, but can be included in the broader ambulatory time. Urgent care visits by patients who are part of the resident's panel or who are part of the practice panel to which the resident belongs will count towards the 130 clinic sessions. It should be emphasized that time spent in a general urgent care clinic where unassigned patients or patients with physicians who are not part of the practice panel will not count towards the 130 clinic sessions. While home visits and group visits are encouraged, these also do not count toward the 130 sessions.</p> <ul style="list-style-type: none"> • Each program will individually determine how each resident achieves his/her own panel of patients and how that panel may be shared with other providers in the practice (e.g. with nurse practitioners, other residents, and faculty). Patients need to be scheduled for residents in a way that assures continuity and gives the resident ample opportunity to care for their panel of patients over the entire three years of training. Patients in the practice will have the majority of their total number of visits with their primary care resident or a member of that resident's team. Residents will be asked whether they follow a panel of patients as part of the Resident Survey. (Updated May 2011 RC Meeting).
<p>What does the Review Committee accept as details of performance data? [Program Requirement IV.A.2.c).(1).(g).(ii).(d)]</p>	<ul style="list-style-type: none"> • Each program should identify appropriate measures that will be reported to and acted upon by the residents. These measures need to be specific to a resident's panel of patients, and not to a practice as a whole. These could include data on patient satisfaction, data regarding chronic medical problems (diabetes, hypertension, coronary artery disease, etc.), and information about preventive health care (immunization rates, cancer screening rates, etc.). The evaluation of these performance data can also occur through the use of the ABIM Performance Improvement Modules (PIMs) or through chart audits/reviews.
<p>What does the Review Committee expect in terms of resident accessibility between outpatient visits? [Program Requirement IV.A.2.c).(1).(g).(ii).(e)]</p>	<ul style="list-style-type: none"> • Programs should develop mechanisms to allow residents to participate in the management of their continuity panel of patients between outpatient visits. These could include: improved communication processes to allow residents to address phone calls on their patients; notification of residents when their patients have been seen by other primary care or subspecialty physicians; notification when a resident's patient is admitted to the hospital. This will be assessed through the Resident Survey.
<p>What are acceptable ways for residents to be able to review core topics if they are unable to attend the scheduled presentation? [Program Requirement: IV.A.3.a).(1)]</p>	<ul style="list-style-type: none"> • The Review Committee accepts a variety of solutions, as long as residents have the opportunity to experience missed educational conferences. <ul style="list-style-type: none"> • The solutions to this issue are all local, and depend partially on why residents miss conference (post-call, day-off, away rotation). • Note that the standard applies to core curriculum conferences. A variety of solutions are acceptable, including but not limited to: <ul style="list-style-type: none"> ○ Videotapes ○ Webcasts ○ Slides available on the web ○ Repeating conferences ○ A parallel conference series at the off-site location
<p>As the ABIM modifies its requirements for procedural competence for residents seeking certification, what are the Review Committee standards for procedural training for residents in core programs? [Program Requirement: IV.A.5.a).(1).(g)]</p>	<ul style="list-style-type: none"> • The Review Committee requires programs to have a written curriculum, for procedures listed by the ABIM, which outlines the indications, contraindications, recognition and management of complications, pain management, sterile techniques, specimen handling (where specimens are obtained), interpretation of results (when appropriate) and requirements and knowledge to obtain informed consent for procedures. These include procedures both where trainees must demonstrate knowledge competency and those where the ABIM requires both knowledge and performance competency.
<p>Evaluation Question</p>	<p>Answer</p>
<p>How does the Review Committee confirm that verbal feedback on continuity clinic performance is given? [Program Requirement: V.A.1.a).(1)]</p>	<ul style="list-style-type: none"> • The Review Committee will examine the PGY-3 responses on the resident survey and the site visitor's report to verify whether this has occurred.
<p>How should resident performance</p>	<ul style="list-style-type: none"> • Resident performance in continuity clinic needs to be documented semi-

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in continuity clinic be evaluated? [Program Requirement: V.A.1.a).(1)]	annually, and must be provided by faculty with whom they have a significant, longitudinal precepting relationship. The feedback must be provided both verbally and in writing. A distinct evaluation tool for this experience may make documentation efficient. Semi-annual feedback from the program director does not meet this requirement unless the program director has a direct precepting relationship with the trainee.
Are competency-based semi-annual evaluations required? [Program Requirement V.A.1.b.1] [Program Requirement V.A.1.b.4.]	<ul style="list-style-type: none"> • Yes. In addition to the program director personally performing the evaluations, feedback on performance related to each of the 6 ACGME competencies must be documented either on a standardized form or by narrative.
What is an acceptable method for documenting direct observation? [Program Requirement: V.A.1.b).(1).(a)]	<ul style="list-style-type: none"> • Direct observation is fulfilled when an attending uses a structured assessment tool (like a mini-CEX, OSCE or checklist) to evaluate a discrete patient-resident encounter (e.g. history, examination, teaching activity, or procedure). The attending must directly observe a resident's performance, and immediately assess performance using an established or locally developed tool. The tool should identify the standard that defines competence in performing the activity. This will ensure that residents and evaluators know what standards need to be met in order to be judged competent.
What is expected for the multi-source evaluations? [Program Requirement V.A.1.b).(2)]	<ul style="list-style-type: none"> • Multi-source evaluations are important in the assessment for several competencies. The goal is to obtain feedback from multiple evaluators who interact with the resident being assessed. These must include at least patients, peers, and non-physician team members (nurses, clerical staff, therapists, etc.). The evaluation of forms distributed to these individuals do not have to each ask about the same items, but should reflect the general domain(s) being assessed (e.g., interpersonal and communication skills, professionalism, systems-based practice).
What are the requirements for evaluations of the faculty by residents? [Program Requirement: V.B.2.]	<ul style="list-style-type: none"> • Each resident must have the opportunity to evaluate each faculty with whom they work, at the end of each rotation period. • The resident evaluations of faculty must be confidential, so that the faculty being evaluated are blinded to the resident's identity. Signed evaluation forms are not compatible with confidentiality. • The evaluations must be reviewed with the faculty annually (and maintain resident confidentiality in review process) for faculty review and counseling (e.g., in the annual review by department chair). • The program must use the evaluations of faculty by residents for selection of faculty for teaching assignments.
Does the annual program review have to occur in only one meeting? [Program Requirement: V.C.1.]	<ul style="list-style-type: none"> • Programs may divide the requirement of an annual program evaluation into monthly sessions, provided these are attended by the program administration, trainees, and faculty. However, the program must demonstrate via written documentation that the program undergoes a comprehensive evaluation with all the elements included in the program requirement each yearly period.
What are the requirements for program evaluation? [Program Requirement: V.C.1.]	<ul style="list-style-type: none"> • Programs must have a process in place for an annual program review of the faculty, curriculum, facilities, etc. • This process is separate and distinct from the GMCE internal reviews that are required mid-cycle by the IReview Committee. In other words, the program conducts annual internal reviews. These annual reviews are rolled up to the institutional GMCE review. • The review panel must include at least one resident and at least one faculty (usually several core faculty or associate program directors). • The results of the review must be documented (minutes, report). • A written plan of action must be formulated if deficiencies are noted. • More information on the annual review process is included in the ACGME's Program Director Guide to the Common Program Requirements.
For the purpose of a program evaluation, what type of inpatient and outpatient faculty performance data must the department share with the program director? [Program Requirement: (V.C.3.)]	<ul style="list-style-type: none"> • The Review Committee believes that it is essential that all faculty are role models for excellent medical practice. It is the department's responsibility to monitor the quality of medical practice of its members, and take appropriate action if there is substandard performance. • The department must provide the program director with information regarding substandard individual practice performance data by the program's faculty. Such information can be presented in summary form. Detailed encounter level information is not required.

Resident Duty Hours in the

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Learning and Working Environment

Question	Answer
<p>What is adequate availability of the faculty for supervision in the hospital? In the clinic? [Program Requirement: VI.D.2.]</p>	<ul style="list-style-type: none"> Residents must be supervised in all settings, and the supervision must be on-site. In inpatient settings, supervision need not be continuous on-site, IF upper level residents or fellows are on-site continuously. In inpatient settings, supervision can occur at specified times such as teaching rounds, with availability at all other times. In outpatient settings, supervision must be continuously available and on-site. Appropriate supervision cannot occur after the patient has left the clinic. Off-site supervision (e.g., attending available by phone if resident has questions) is not acceptable in outpatient settings. Rationale: The attending must have the opportunity to interview/examine all patients at the time he/ she reviews the case and provides supervision. Learners do not always realize when additional evaluation or a change in care plan is necessary.
<p>Can nurse practitioners or physician assistants supervise residents or fellows in ambulatory settings? [Program Requirement: VI.D.2.]</p>	<ul style="list-style-type: none"> The Review Committee will allow supervision by non-physician faculty in specialized outpatient settings for specific learning experiences (i.e., GYN clinic, STD clinic, wound care clinic, home visits, nursing homes, etc.) where the non-physician faculty have the appropriate qualifications to perform and supervise the clinical activity. If the non-physician faculty is acting as a supervisor of the health care provided in a particular setting, the program must assure that the non-physician faculty is authorized to do so by applicable institutional policies and state regulations. Under no circumstances does this exception to physician faculty supervision apply to continuity clinic, other general medical clinics or medicine subspecialty clinics (i.e., pulmonary clinic, general infectious disease clinic, heme-onc clinic, etc.).
<p>Can nurse practitioners or physician assistants supervise residents or fellows on inpatient rotations? [Program Requirement: VI.D.2.]</p>	<ul style="list-style-type: none"> Although the Review Committee believes that it is important for Medicine residents and fellows to acquire experience in leading and participating in healthcare teams, including those with non-physicians (e.g., nurse practitioners or physician assistants), overall supervision of all clinical care rendered by residents and fellows is the responsibility of the physician faculty and the attending physician of record. Non-physicians are not permitted to independently supervise Medicine residents and fellows on inpatient rotations. Nevertheless, the attending physician may delegate an appropriately qualified non-physician to assist a resident or fellow in performing a procedure. However, the ultimate responsibility for supervision remains the responsibility of the attending physician.
<p>Are emergency department shifts longer than 12 hours permissible to allow transfer of care? [Program Requirement: VI.D.5.]</p>	<ul style="list-style-type: none"> No. The Review Committee expects that all clinical activities on ER rotations, including sign-in and sign-out, will be concluded within the maximum 12-hour duty period. Programs have been cited consistently for violating this standard. The Review Committee does not suggest that 12 hours is an optimal shift length for ED rotations, but sets 12 hours as the absolute maximum duty period. Many programs have found 8-hour or 10-hour shifts to provide a better service-education balance in the ED. Shorter shifts also allow for sign-in and sign-out while still staying under the 12-hour limit. Some programs have assigned residents to cover only 18 or 20 hours of the 24-hour day, with faculty covering the additional period. Other programs have scheduled faculty shifts to overlap resident shifts, allowing residents to sign out to faculty.