

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Infectious Disease (Internal Medicine)**

3
4 **Common Program Requirements are in BOLD**
5 *General Subspecialty Requirements are ITALICIZED*
6

7 Effective: July 1, 2012
8

9 **Introduction**

10
11 **Int.A. Residency is an essential dimension of the transformation of the medical**
12 **student to the independent practitioner along the continuum of medical**
13 **education. It is physically, emotionally, and intellectually demanding, and**
14 **requires longitudinally-concentrated effort on the part of the resident.**
15

16 **The specialty education of physicians to practice independently is**
17 **experiential, and necessarily occurs within the context of the health care**
18 **delivery system. Developing the skills, knowledge, and attitudes leading to**
19 **proficiency in all the domains of clinical competency requires the resident**
20 **physician to assume personal responsibility for the care of individual**
21 **patients. For the resident, the essential learning activity is interaction with**
22 **patients under the guidance and supervision of faculty members who give**
23 **value, context, and meaning to those interactions. As residents gain**
24 **experience and demonstrate growth in their ability to care for patients, they**
25 **assume roles that permit them to exercise those skills with greater**
26 **independence. This concept—graded and progressive responsibility—is**
27 **one of the core tenets of American graduate medical education.**
28 **Supervision in the setting of graduate medical education has the goals of**
29 **assuring the provision of safe and effective care to the individual patient;**
30 **assuring each resident’s development of the skills, knowledge, and**
31 **attitudes required to enter the unsupervised practice of medicine; and**
32 **establishing a foundation for continued professional growth.**
33

34 **Int.B. ~~Subspecialty programs must~~ Infectious disease fellowships provide advanced**
35 **~~training~~ education to allow ~~the a~~ fellow to acquire competency in the subspecialty**
36 **with sufficient expertise to act as an independent consultant.**
37

38 **Int.C. ~~An accredited fellowship~~ The educational program in infectious disease must**
39 **~~provide~~ be 24 months of supervised graduate medical education in length.**
40

41 **I. Institutions**

42
43 **I.A. Sponsoring Institution**
44

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

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

- 52
53 I.A.1. An infection disease fellowship must function as an integral part of an
54 ACGME-accredited ~~education~~ program in internal medicine.
55
56 I.A.2. *The sponsoring institution must:*
57
58 I.A.2.a) *establish the infectious disease fellowship within a department of*
59 *internal medicine or an administrative unit whose primary mission*
60 *is the advancement of internal medicine subspecialty education*
61 *and patient care; and,*
62
63 I.A.2.b) ~~provide ensure~~ *the program director with adequate support for the*
64 *administrative activities of the ~~internal medicine subspecialty~~*
65 *~~program~~ fellowship.*
66
67 I.A.2.b).(1) *The program director must not be required to generate*
68 *clinical or other income to provide this administrative*
69 *support.*
70
71 I.A.2.b).(2) ~~It is suggested~~ *This support should be 25-50% of the*
72 *program director's salary, or protected time depending on*
73 *the size of the program.*
74
75 I.A.3. *The sponsoring institution and participating ~~institutions~~ sites must:*
76
77 I.A.3.a) ~~demonstrate that there is a culture of continuous quality~~
78 ~~improvement in the areas of patient care, patient safety, and~~
79 ~~education;~~
80
81 I.A.3.b) ~~demonstrate a commitment to~~ quality patient-centered care and
82 safety, ~~education, research and~~ scholarship ~~sufficient to support~~
83 ~~the fellowship program; and,~~
84
85 I.A.3.c) ~~share appropriate inpatient and outpatient faculty performance~~
86 ~~data with the program director.~~
87
88 I.A.3.d) ~~provide fellow compensation, and benefits, faculty, facilities, and~~
89 ~~resources for education, clinical care, and research required for~~
90 ~~accreditation;~~
91
92 I.A.3.e) ~~notify the Review Committee within 60 days of changes in~~
93 ~~institutional governance, affiliation, or resources that affect the~~
94 ~~educational program as outlined in the Institutional Requirements;~~
95 ~~and~~
96
97 I.A.3.f) ~~provide fellowship positions in each training program that do not~~
98 ~~number less than the number of accredited training years in the~~
99 ~~program~~

100
101 **I.B. Participating Sites**
102

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

106
107 The PLA should:

108
109 **I.B.1.a)** identify the faculty who will assume both educational and
110 supervisory responsibilities for fellows;

111
112 **I.B.1.b)** specify their responsibilities for teaching, supervision, and
113 formal evaluation of fellows, as specified later in this
114 document;

115
116 **I.B.1.c)** specify the duration and content of the educational
117 experience; and

118
119 **I.B.1.d)** state the policies and procedures that will govern fellow
120 education during the assignment.

121
122 **I.B.2.** The program director must submit any additions or deletions of
123 participating sites routinely providing an educational experience,
124 required for all fellows, of one month full time equivalent (FTE) or
125 more through the Accreditation Council for Graduate Medical
126 Education (ACGME) Accreditation Data System (ADS).

127
128 **II. Program Personnel and Resources**

129
130 **II.A. Program Director**

131
132 **II.A.1.** There must be a single program director with authority and
133 accountability for the operation of the program. The sponsoring
134 institution's GMEC must approve a change in program director. After
135 approval, the program director must submit this change to the
136 ACGME via the ADS.

137
138 **II.A.2.** The program director should continue in his or her position for a
139 length of time adequate to maintain continuity of leadership and
140 program stability.

141
142 **II.A.3.** Qualifications of the program director must include:

143
144 **II.A.3.a)** requisite specialty expertise and documented educational
145 and administrative experience acceptable to the Review
146 Committee;

147
148 **II.A.3.a).(1)** The program director must have at least five years of
149 participation as an active faculty member in an ACGME-
150 accredited internal medicine residency or infectious
151 disease fellowship program.

152

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

203		
204	II.A.4.j).(2)	monitor fellow duty hours, according to sponsoring
205		institutional policies, with a frequency sufficient to
206		ensure compliance with ACGME requirements;
207		
208	II.A.4.j).(3)	adjust schedules as necessary to mitigate excessive
209		service demands and/or fatigue; and
210		
211	II.A.4.j).(4)	if applicable, monitor the demands of at-home call and
212		adjust schedules as necessary to mitigate excessive
213		service demands and/or fatigue.
214		
215	II.A.4.k)	monitor the need for and ensure the provision of back up
216		support systems when patient care responsibilities are
217		unusually difficult or prolonged;
218		
219	II.A.4.l)	comply with the sponsoring institution's written policies and
220		procedures, including those specified in Institutional
221		Requirements, for selection, evaluation and promotion of
222		fellows, disciplinary action, and supervision of fellows;
223		
224	II.A.4.m)	be familiar with and comply with ACGME and Review
225		Committee policies and procedures as outlined in the ACGME
226		Manual of Policies and Procedures;
227		
228	II.A.4.n)	obtain review and approval of the sponsoring institution's
229		GMEC/DIO before submitting to the ACGME information or
230		requests for the following:
231		
232	II.A.4.n).(1)	all applications for ACGME accreditation of new
233		programs;
234		
235	II.A.4.n).(2)	changes in fellow complement;
236		
237	II.A.4.n).(3)	major changes in program structure or length of
238		training;
239		
240	II.A.4.n).(4)	progress reports requested by the Review Committee;
241		
242	II.A.4.n).(5)	responses to all proposed adverse actions;
243		
244	II.A.4.n).(6)	requests for increases or any change to fellow duty
245		hours;
246		
247	II.A.4.n).(7)	voluntary withdrawals of ACGME-accredited
248		programs;
249		
250	II.A.4.n).(8)	requests for appeal of an adverse action;
251		
252	II.A.4.n).(9)	appeal presentations to a Board of Appeal or the

- 253 **ACGME; and**
- 254
- 255 **II.A.4.n).(10) proposals to ACGME for approval of innovative**
- 256 **educational approaches.**
- 257
- 258 **II.A.4.o) obtain DIO review and co-signature on all program**
- 259 **information forms, as well as any correspondence or**
- 260 **document submitted to the ACGME that addresses:**
- 261
- 262 **II.A.4.o).(1) program citations; and/or**
- 263
- 264 **II.A.4.o).(2) request for changes in the program that would have**
- 265 **significant impact, including financial, on the program**
- 266 **or institution.**
- 267
- 268 *II.A.4.p) be responsible for monitoring fellow stress, including mental or*
- 269 *emotional conditions inhibiting performance or learning, and drug-*
- 270 *or alcohol-related dysfunction;*
- 271
- 272 *II.A.4.p).(1) ~~Both~~ The program director ~~and faculty~~ should provide*
- 273 *access to be sensitive to the need for timely provision of*
- 274 *confidential counseling and psychological support services*
- 275 *to fellows.*
- 276
- 277 *II.A.4.p).(2) Situations that demand excessive service or that*
- 278 *consistently produce undesirable stress on fellows must be*
- 279 *evaluated and modified.*
- 280
- 281 *II.A.4.q) ensure that fellows' service responsibilities are limited to patients*
- 282 *for whom the teaching service has diagnostic and therapeutic*
- 283 *responsibility.*
- 284
- 285 *II.A.4.r) dedicate an average of 20 hours per week of his or her*
- 286 *professional effort to the ~~internal medicine subspecialty program~~*
- 287 *fellowship, including with sufficient time for administration of the*
- 288 *program, and receive institutional support for that administrative*
- 289 *time.*
- 290
- 291 *II.A.4.s) participate in academic societies and in educational programs*
- 292 *designed to enhance his or her educational and administrative*
- 293 *skills;*
- 294
- 295 *II.A.4.t) have a reporting relationship with the program director of the*
- 296 *parent internal medicine residency program to ensure compliance*
- 297 *with the ACGME accreditation standards; and,*
- 298
- 299 *II.A.4.u) be available ~~located~~ at the primary principal clinical site.*
- 300
- 301 **II.B. Faculty**
- 302
- 303 **II.B.1. At each participating site, there must be a sufficient number of**

- 304 faculty with documented qualifications to instruct and supervise all
 305 fellows at that location.
 306
 307 The faculty must:
 308
- 309 **II.B.1.a)** devote sufficient time to the educational program to fulfill
 310 their supervisory and teaching responsibilities; and to
 311 demonstrate a strong interest in the education of fellows; and
 312
 - 313 **II.B.1.b)** administer and maintain an educational environment
 314 conducive to educating fellows in each of the ACGME
 315 competency areas.
 316
 - 317 **II.B.2.** The physician faculty must have current certification in the
 318 subspecialty by the American Board of Internal Medicine, or possess
 319 qualifications acceptable by the Review Committee.
 320
 - 321 **II.B.3.** The physician faculty must possess current medical licensure and
 322 appropriate medical staff appointment.
 323
 - 324 **II.B.4.** The nonphysician faculty must have appropriate qualifications in
 325 their field and hold appropriate institutional appointments.
 - 326 **II.B.5.** The faculty must establish and maintain an environment of inquiry
 327 and scholarship with an active research component.
 328
 - 329 **II.B.5.a)** The faculty must regularly participate in organized clinical
 330 discussions, rounds, journal clubs, and conferences.
 331
 - 332 **II.B.5.b)** Some members of the faculty should also demonstrate
 333 scholarship by one or more of the following:
 334
 - 335 **II.B.5.b).(1)** peer-reviewed funding;
 336
 - 337 **II.B.5.b).(2)** publication of original research or review articles in
 338 peer-reviewed journals or chapters in textbooks;
 339
 - 340 **II.B.5.b).(3)** publication or presentation of case reports or clinical
 341 series at local, regional, or national professional and
 342 scientific society meetings; or
 343
 - 344 **II.B.5.b).(4)** participation in national committees or educational
 345 organizations.
 346
 - 347 **II.B.5.c)** Faculty should encourage and support fellows in scholarly
 348 activities.
 349
 - 350 **II.B.6.** *The physician faculty must meet professional standards of ethical*
 351 *behavior.*
 352
 - 353 **II.B.7.** Key Clinical Faculty

354
355 In addition to the program director, each program must have at least one
356 ~~two~~ Key Clinical Faculty (KCF). KCF are attending physicians who
357 dedicate, on average, 10 hours per week throughout the year to the
358 ~~training program.~~ For programs with more than five-three fellows, ~~enrolled~~
359 ~~during the accredited portion of the training program,~~ a ratio of key clinical
360 faculty to fellows of at least 1: ~~there must be at least one KCF for every~~
361 1.5 fellows ~~must be maintained.~~

362
363 II.B.7.a) Key Clinical Faculty Qualifications

364
365 II.B.7.a).(1) KCF must be active clinicians with ~~broad~~ knowledge of,
366 experience with, and commitment to infectious disease as
367 a discipline.

368
369 II.B.7.a).(2) KCF must have current ABIM certification in infectious
370 disease.

371
372 II.B.7.b) Key Clinical Faculty Responsibilities

373
374 II.B.7.b).(1) *In addition to the responsibilities of all individual faculty_*
375 *members, the KCF and the program director are*
376 *responsible for the planning, implementation, monitoring*
377 *and evaluation of the fellows' clinical and research*
378 *education-training.*

379
380 II.B.7.b).(2) ~~The majority of~~ At least 50% of the KCF must demonstrate
381 evidence of productivity in ~~the~~ scholarship, specifically,
382 peer-reviewed funding; publication of original research,
383 review articles, editorials, or case reports in peer-reviewed
384 journals; or chapters in textbooks. ~~as defined in II.B.5.b.(1),~~
385 ~~or (2) above.~~

386
387 II.B.7.b).(3) At least one of the KCF must:

388
389 II.B.7.b).(3).(a) be knowledgeable in the evaluation and
390 assessment of the fellows in the ACGME
391 competencies; and,

392
393 II.B.7.b).(3).(b) spend significant time in the evaluation of fellows,
394 including the direct observation of fellows with
395 patients.

396
397 II.B.7.b).(4) Appointment of one KCF to be an associate program
398 director is suggested.

399
400 II.B.8. ~~All~~ *Clinical faculty members should participate in ~~prescribed~~ faculty*
401 *development programs designed to enhance the effectiveness of their*
402 *teaching.*

403
404 II.C. Other Program Personnel

405
406 **The institution and the program must jointly ensure the availability of all**
407 **necessary professional, technical, and clerical personnel for the effective**
408 **administration the program.**

409
410 *II.C.1. There must be services available from other health care professionals,*
411 *including dietitians, language interpreters, nurses, occupational*
412 *therapists, physical therapists, and social workers.*

413
414 *II.C.2. There must be ensure the availability of appropriate and timely*
415 *consultation from other specialties.*

416
417 **II.D. Resources**

418
419 **The institution and the program must jointly ensure the availability of**
420 **adequate resources for fellow education, as defined in the specialty**
421 **program requirements.**

422
423 *II.D.1. Space and Equipment*

424
425 *There must be space and equipment for the ~~educational~~ program,*
426 *including meeting rooms, ~~classrooms,~~ examination rooms, computers,*
427 *visual and other educational aids, and work/study space.*

428
429 *II.D.2. Facilities*

430
431 *II.D.2.a) Inpatient and outpatient systems must be in place to prevent*
432 *fellows from performing routine clerical functions, such as*
433 *scheduling tests and appointments, and retrieving records and*
434 *letters.*

435
436 *II.D.2.b) The sponsoring institution must provide the broad range of*
437 *facilities and clinical support services required to provide*
438 *comprehensive care of adult patients. Fellows must have clinical*
439 *experiences in efficient, effective ambulatory and inpatient care*
440 *settings.*

441
442 *II.D.2.c) Fellows must have access to a lounge facility during assigned*
443 *duty hours.*

444
445 *II.D.2.d) When fellows are ~~assigned night duty~~ in the hospital, assigned*
446 *night duty, or called in from home, they must be provided with ~~on-~~*
447 *~~call facilities that are convenient and that afford privacy, safety,~~*
448 *~~and a restful environment with~~ a secure space for their*
449 *belongings.*

450
451 *II.D.2.e) Fellows must have convenient access to a laboratory for clinical*
452 *microbiology, such that direct and frequent interaction with*
453 *microbiology laboratory personnel is readily available.*

454
455 *II.D.2.f) Facilities for the isolation of patients with infectious diseases must*

456 be available.

457

458 II.D.3. Other Facilities, Resources, or Support Services

459

460 It is suggested that clinical ~~training~~ education be conducted in settings

461 that also have ACGME-accredited ~~training~~ programs in surgery, obstetrics

462 and gynecology, pediatrics, and other medical and surgical

463 subspecialties.

464

465 II.D.4. *Medical Records*

466

467 Access to an electronic health record should be provided. In the absence

468 of an existing electronic health record, institutions must demonstrate

469 institutional commitment to its development and progress toward its

470 implementation.

471

472 II.D.5. Patient Population

473

474 II.D.5.a) The patient population must have a variety of clinical problems

475 and stages of diseases.

476

477 II.D.5.b) *There must be patients of each ~~gender~~ both sexes, with a broad*

478 *age range, including geriatric patients.*

479

480 II.D.5.c) *A sufficient number of patients must be available to enable ~~ensure~~*

481 *adequate inpatient and ambulatory experience for each fellow to*

482 *achieve the required educational outcomes.*

483

484 **II.E. Medical Information Access**

485

486 **Fellows must have ready access to specialty-specific and other appropriate**

487 **reference material in print or electronic format. Electronic medical literature**

488 **databases with search capabilities should be available.**

489

490 **III. Fellow Appointments**

491

492 **III.A. Eligibility Criteria**

493

494 **The program director must comply with the criteria for fellow eligibility as**

495 **specified in the Institutional Requirements.**

496

497 III.A.1. Prior to appointment in the fellowship, fellows ~~appointed~~ should have

498 completed an ACGME-accredited internal medicine ~~education~~ program.

499

500 III.A.2. Fellows from non-ACGME-~~accredited~~ internal medicine ~~education~~

501 programs must have at least three years of internal medicine education

502 prior to starting the fellowship.

503

504 III.A.3. The program director must inform ~~non-ACGME-trained~~ applicants from

505 non-ACGME-accredited programs, prior to appointment, and in writing, of

506 the ABIM policies and procedures that may will affect the fellow's their

507 eligibility for ABIM certification.
508
509 ~~III.A.4.~~ *When averaged over any five-year period, a minimum of 75% of fellows in*
510 *each ~~subspecialty training program~~ must be graduates of an ACGME-*
511 *accredited internal medicine ~~training program~~. ~~Non-ACGME internal~~*
512 *medicine trained fellows must have at least three years of internal*
513 *medicine training prior to starting fellowship.*
514
515 **III.B. Number of Fellows**
516
517 **The program director may not appoint more fellows than approved by the**
518 **Review Committee, unless otherwise stated in the specialty-specific**
519 **requirements. The program's educational resources must be adequate to**
520 **support the number of fellows appointed to the program.**
521
522 III.B.1. *The ~~minimum~~ number of available fellow positions in the training program*
523 *must be at least one per year ~~not be less than the number of accredited~~*
524 *~~training years in the program.~~*
525
526 **III.C. Fellow Transfers**
527
528 **III.C.1. Before accepting a fellow who is transferring from another program,**
529 **the program director must obtain written or electronic verification of**
530 **previous educational experiences and a summative competency-**
531 **based performance evaluation of the transferring fellow.**
532
533 **III.C.2. A program director must provide timely verification of fellowship**
534 **education and summative performance evaluations for fellows who**
535 **leave the program prior to completion.**
536
537 **III.D. Appointment of Fellows and Other Learners**
538
539 **The presence of other learners (including, but not limited to, residents from**
540 **other specialties, subspecialty fellows, PhD students, and nurse**
541 **practitioners) in the program must not interfere with the appointed fellows'**
542 **education. The program director must report the presence of other learners**
543 **to the DIO and GMEC in accordance with sponsoring institution guidelines.**
544
545 **IV. Educational Program**
546
547 **IV.A. The curriculum must contain the following educational components:**
548
549 **IV.A.1. Overall educational goals for the program, which the program must**
550 **distribute to fellows and faculty annually;**
551
552 **IV.A.2. Competency-based goals and objectives for each assignment at**
553 **each educational level, which the program must distribute to fellows**
554 **and faculty annually, in either written or electronic form. These**
555 **should be reviewed by the fellow at the start of each rotation;**
556

557 **IV.A.3. Regularly scheduled didactic sessions; and**
558
559 *IV.A.3.a) The core curriculum must include a didactic program based upon*
560 *the core knowledge content in the subspecialty area.*
561
562 *IV.A.3.a).(1) The program must afford each fellow an opportunity to*
563 *review topics covered in conferences that he or she was*
564 *unable to attend.*
565
566 *IV.A.3.a).(2) Fellows must participate in clinical case conferences,*
567 *journal clubs, research conferences, and morbidity and*
568 *mortality or quality improvement conferences.*
569
570 *IV.A.3.a).(3) All core conferences must have at least one faculty*
571 *member present, and must be scheduled as to ensure*
572 *peer-peer and peer-faculty interaction.*
573
574 *IV.A.3.b) Patient-based teaching must include direct interaction between*
575 *fellows and ~~attendings~~ faculty members, bedside teaching,*
576 *discussion of pathophysiology, and the use of current evidence in*
577 *diagnostic and therapeutic decisions. The teaching must be:*
578
579 | *IV.A.3.b).(1) formally conducted on all inpatient, outpatient, and*
580 *consultative services; and,*
581
582 *IV.A.3.b).(2) conducted with a frequency and duration ~~sufficient to that~~*
583 *ensures a meaningful and continuous teaching relationship*
584 *between the assigned supervising faculty member(s)*
585 *teaching attending and fellows.*
586
587 *IV.A.3.c) Fellows must receive instruction in practice management relevant*
588 *to infectious disease.*
589
590 **IV.A.4. Delineation of fellow responsibilities for patient care, progressive**
591 **responsibility for patient management, and supervision of fellows**
592 **over the continuum of the program.**
593
594 **IV.A.5. ACGME Competencies**
595
596 **The program must integrate the following ACGME competencies**
597 **into the curriculum:**
598
599 **IV.A.5.a) Patient Care**
600
601 **Fellows must be able to provide patient care that is**
602 **compassionate, appropriate, and effective for the treatment of**
603 **health problems and the promotion of health. Fellows:**
604
605 | *IV.A.5.a).(1) must demonstrate competence in the practice of health*
606 *promotion, disease prevention, diagnosis, care, and*
607 *treatment of ~~men and women~~ patients of each gender from*

608 *adolescence to old age, during health and all stages of*
609 *illness;*

610
611 IV.A.5.a).(2) must demonstrate competence in the diagnosis and
612 management of the following infectious disease areas-
613 problems:

614
615 IV.A.5.a).(2).(a) bacterial infections;

616
617 IV.A.5.a).(2).(b) fungal infections;

618
619 IV.A.5.a).(2).(c) health care-associated infections;

620
621 IV.A.5.a).(2).(d) HIV/AIDS;

622
623 IV.A.5.a).(2).(e) infections in patients with impaired host defenses;

624
625 IV.A.5.a).(2).(f) infections in patients in intensive care units;

626
627 IV.A.5.a).(2).(g) infections in surgical patients;

628
629 IV.A.5.a).(2).(h) infections in travelers;

630
631 IV.A.5.a).(2).(i) parasitic infections;

632
633 IV.A.5.a).(2).(j) prosthetic device infections;

634
635 IV.A.5.a).(2).(k) sepsis syndromes;

636
637 IV.A.5.a).(2).(l) sexually transmitted infections; and,

638
639 IV.A.5.a).(2).(m) viral infections.

640
641 ~~IV.A.5.a).(2).(n) Initiating antiretroviral therapy~~

642
643 ~~IV.A.5.a).(2).(o) Changing antiretroviral therapy in the patient with~~
644 ~~toxicity or treatment failure, including the~~
645 ~~interpretation of resistance test results~~

646
647 ~~IV.A.5.a).(2).(p) Longitudinal disease management~~

648
649 ~~IV.A.5.a).(2).(q) Counseling on prevention of transmission and~~
650 ~~acquisition of HIV~~

651
652 **IV.A.5.b) Medical Knowledge**

653
654 **Fellows must demonstrate knowledge of established and**
655 **evolving biomedical, clinical, epidemiological and social-**
656 **behavioral sciences, as well as the application of this**
657 **knowledge to patient care. Fellows:**

658

659	IV.A.5.b).(1)	are expected to learn must demonstrate knowledge of the scientific method of problem solving and evidence-based decision making; a commitment to lifelong learning, and an attitude of caring that is derived from humanistic and professional values.
660		
661		
662		
663		
664		
665	IV.A.5.b).(2)	must develop <u>demonstrate knowledge understanding of</u> indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline, <u>including the appropriate indications for and use of screening tests/procedures;</u>
666		
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671		
672	IV.A.5.b).(3)	are expected to master <u>must demonstrate knowledge of</u> the cognitive aspects of:
673		
674		
675	IV.A.5.b).(3).(a)	the mechanisms of action and adverse reactions of antimicrobial agents, antimicrobial and antiviral resistance, drug-drug interactions between antimicrobial agents and other compounds;
676		
677		
678		
679		
680	IV.A.5.b).(3).(b)	the appropriate use and management of antimicrobial agents in a variety of clinical settings, including the hospital, ambulatory practice, non-acute-care units, and the home;
681		
682		
683		
684		
685	IV.A.5.b).(3).(c)	methods of determining antimicrobial activity of a drug; techniques to determine concentration of antimicrobial agents in the blood and other body fluids; interpretation of antibiotic levels in blood; the appropriate procedures for specimen collection relevant to infectious disease, including but not limited to bronchoscopy, thoracentesis, arthrocentesis, lumbar puncture, and aspiration of abscess cavities;
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694		
695	IV.A.5.b).(3).(d)	the principles of prophylaxis and immunoprophylaxis to enhance resistance to infection;
696		
697		
698		
699	IV.A.5.b).(3).(e)	the characteristics, use, and complications of antiretroviral agents, mechanisms and clinical significance of viral resistance to antiretroviral agents, and recognition and management of opportunistic infections in patients with HIV/AIDS; and,
700		
701		
702		
703		
704		
705		
706	IV.A.5.b).(3).(f)	the fundamentals of host defense and mechanisms of microorganism pathogenesis. including innate and adaptive immunity and perturbations that predispose to infection; and,
707		
708		
709		

- 710
 711 IV.A.5.b).(3).(g) immunizations and postexposure prophylaxis.
 712
 713 IV.A.5.b).(4) understand and participate in must demonstrate
 714 knowledge of the development of appropriate antibiotic
 715 utilizations and restriction policies; and,
 716
 717 IV.A.5.b).(5) understand the principles must demonstrate knowledge of
 718 infection control and hospital epidemiology-outbreak-
 719 investigation.
 720

721 **IV.A.5.c)**

Practice-based Learning and Improvement

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

- 729
 730 **IV.A.5.c).(1)** identify strengths, deficiencies, and limits in one's
 731 knowledge and expertise;
 732
 733 **IV.A.5.c).(2)** set learning and improvement goals;
 734
 735 **IV.A.5.c).(3)** identify and perform appropriate learning activities;
 736
 737 **IV.A.5.c).(4)** systematically analyze practice, using quality
 738 improvement methods, and implement changes with
 739 the goal of practice improvement;
 740
 741 **IV.A.5.c).(5)** incorporate formative evaluation feedback into daily
 742 practice;
 743
 744 **IV.A.5.c).(6)** locate, appraise, and assimilate evidence from
 745 scientific studies related to their patients' health
 746 problems;
 747
 748 **IV.A.5.c).(7)** use information technology to optimize learning; and,
 749
 750 **IV.A.5.c).(8)** participate in the education of patients, families,
 751 students, fellows and other health professionals.
 752

753 **IV.A.5.d)**

Interpersonal and Communication Skills

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

759

- 760 **IV.A.5.d).(1)** communicate effectively with patients, families, and
 761 the public, as appropriate, across a broad range of
 762 socioeconomic and cultural backgrounds;
 763
- 764 **IV.A.5.d).(2)** communicate effectively with physicians, other health
 765 professionals, and health related agencies;
 766
- 767 **IV.A.5.d).(3)** work effectively as a member or leader of a health care
 768 team or other professional group;
 769
- 770 **IV.A.5.d).(4)** act in a consultative role to other physicians and
 771 health professionals; and,
 772
- 773 **IV.A.5.d).(5)** maintain comprehensive, timely, and legible medical
 774 records, if applicable.
 775

776 **IV.A.5.e)** Professionalism

777
 778 **Fellows must demonstrate a commitment to carrying out**
 779 **professional responsibilities and an adherence to ethical**
 780 **principles. Fellows are expected to demonstrate:**

- 781
- 782 **IV.A.5.e).(1)** compassion, integrity, and respect for others;
 783
- 784 **IV.A.5.e).(2)** responsiveness to patient needs that supersedes self-
 785 interest;
 786
- 787 **IV.A.5.e).(3)** respect for patient privacy and autonomy;
 788
- 789 **IV.A.5.e).(4)** accountability to patients, society and the profession;
 790
- 791 **IV.A.5.e).(5)** sensitivity and responsiveness to a diverse patient
 792 population, including but not limited to diversity in
 793 gender, age, culture, race, religion, disabilities, and
 794 sexual orientation;
 795
- 796 *IV.A.5.e).(6)* high standards of ethical behavior, including maintaining
 797 appropriate professional boundaries and relationships with
 798 other physicians and other health care team members, and
 799 avoiding conflicts of interest; and.
 800
- 801 *IV.A.5.e).(7)* a commitment to lifelong learning, and an attitude of caring
 802 derived from humanistic and professional values.
 803

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

805
 806 **Fellows must demonstrate an awareness of and**
 807 **responsiveness to the larger context and system of health**
 808 **care, as well as the ability to call effectively on other**
 809 **resources in the system to provide optimal health care.**

- 810 **Fellows are expected to:**
- 811
- 812 **IV.A.5.f).(1) work effectively in various health care delivery**
- 813 **settings and systems relevant to their clinical**
- 814 **specialty;**
- 815
- 816 **IV.A.5.f).(2) coordinate patient care within the health care system**
- 817 **relevant to their clinical specialty;**
- 818
- 819 **IV.A.5.f).(3) incorporate considerations of cost awareness and**
- 820 **risk-benefit analysis in patient and/or population-**
- 821 **based care as appropriate;**
- 822
- 823 **IV.A.5.f).(4) advocate for quality patient care and optimal patient**
- 824 **care systems;**
- 825
- 826 **IV.A.5.f).(5) work in interprofessional teams to enhance patient**
- 827 **safety and improve patient care quality; and,**
- 828
- 829 **IV.A.5.f).(6) participate in identifying system errors and**
- 830 **implementing potential systems solutions.**
- 831
- 832 ~~IV.A.5.f).(7) Manage with consideration of cost of therapy, insurance,~~
- 833 ~~and social situation of patient~~

834

835 **IV.A.6. Curriculum Organization and Fellow Experiences**

836

- 837 **IV.A.6.a) A minimum of 12 months must be devoted to clinical experience.**
- 838
- 839 **IV.A.6.b) Fellows must participate in ~~the management of discharge planning~~**
- 840 **~~of patients on long-term oral and parenteral antibiotics, including~~**
- 841 **~~insuring safe follow-up of laboratory monitoring. outpatient~~**
- 842 **antibiotic therapy, including interaction with pharmacy, nursing,**
- 843 **and other home care services.**
- 844
- 845 **IV.A.6.c) Fellows must participate in training using simulation.**
- 846
- 847 **IV.A.6.d) Experience with Continuity Ambulatory Patients**
- 848
- 849 **Fellows must have continuity ambulatory clinic experience to**
- 850 **~~develop a continuous healing relationship with patients for whom~~**
- 851 **~~they provide subspecialty care. This continuity experience should~~**
- 852 **that exposes them fellows to the breadth and depth of infectious**
- 853 **disease.**
- 854
- 855 **IV.A.6.d).(1) ~~Overall~~ This experience should average one half-day each**
- 856 **week.**
- 857
- 858 **IV.A.6.d).(2) ~~Overall~~ This experience must include an appropriate**
- 859 **distribution of patients of each ~~both~~ gender and a diversity**

- 860 of ages, ~~which~~. This should be accomplished ~~by~~ through
861 either:
862
- 863 IV.A.6.d).(2).(a) a continuity clinic which provides fellows the
864 opportunity to learn the course of disease; or,
865
- 866 IV.A.6.d).(2).(b) selected blocks of at least six months which
867 address specific areas of infectious disease.
868
- 869 IV.A.6.d).(3) Ambulatory experience must include the longitudinal care
870 of patients with HIV infection under the supervision of a
871 physician experienced in the management of HIV infection.
872
- 873 IV.A.6.d).(3).(a) Fellows must be assigned to an HIV clinic for a
874 period of at least 12 months.
875
- 876 IV.A.6.d).(4) Each fellow should, on average, be responsible for four to
877 eight patients during each half-day session.
878
- 879 IV.A.6.d).(5) The continuing patient care experience should not be
880 interrupted by more than one month, excluding a fellow's
881 vacation.
882
- 883 IV.A.6.d).(6) ~~It is suggested that~~ Fellows should be informed of the
884 status of their continuity patients when ~~they~~ such patients
885 are hospitalized, as clinically appropriate. ~~so the fellows~~
886 ~~can make appropriate arrangements to maintain continuity~~
887 ~~of care.~~
888
- 889 ~~IV.A.6.d).(7) Ambulatory training must include longitudinal care of at~~
890 ~~least 20 patients with HIV infection over 12 months under~~
891 ~~the supervision of an experienced HIV physician.~~
892
- 893 IV.A.6.e) Consultations
894
895 Each fellow must provide patient care consultations or directly
896 oversee students or residents performing consultations totaling at
897 least 250 new patient consults with infectious disease problems.
898
- 899 IV.A.6.f) Experience with pediatric infectious diseases is suggested.
900
- 901 **IV.B. Fellows' Scholarly Activities**
902
- 903 **IV.B.1. The curriculum must advance fellows' knowledge of the basic**
904 **principles of research, including how research is conducted,**
905 **evaluated, explained to patients, and applied to patient care.**
906
- 907 **IV.B.2. Fellows should participate in scholarly activity.**
908
- 909 *IV.B.2.a) ~~The majority of fellows must demonstrate evidence of recent~~*
910 *~~research productivity~~ scholarship conducted during the fellowship*

911 through one or more of the following:
912
913 IV.B.2.a).(1) publication of articles, book chapters, abstracts or case
914 reports in peer-reviewed journals;
915
916 IV.B.2.a).(2) publication of peer-reviewed performance improvement or
917 education research;
918
919 IV.B.2.a).(3) peer-reviewed funding; or,
920
921 IV.B.2.a).(4) peer-reviewed abstracts presented at regional, state or
922 national specialty meetings.
923
924 **IV.B.3. The sponsoring institution and program should allocate adequate**
925 **educational resources to facilitate fellow involvement in scholarly**
926 **activities.**
927
928 **V. Evaluation**
929
930 **V.A. Fellow**
931
932 **V.A.1. Formative Evaluation**
933
934 **V.A.1.a) The faculty must evaluate fellow performance in a timely**
935 **manner during each rotation or similar educational**
936 **assignment, and document this evaluation at completion of**
937 **the assignment.**
938
939 V.A.1.a).(1) The faculty must discuss this evaluation with ~~the~~ each
940 fellow at the completion of ~~the~~ each ~~the~~ assignment.
941
942 V.A.1.a).(2) Assessment of procedural competence should include a
943 formal evaluation process and not be based solely on a
944 minimum number of procedures performed.
945
946 **V.A.1.b) The program must:**
947
948 **V.A.1.b).(1) provide objective assessments of competence in**
949 **patient care, medical knowledge, practice-based**
950 **learning and improvement, interpersonal and**
951 **communication skills, professionalism, and systems-**
952 **based practice;**
953
954 V.A.1.b).(1).(a) Patient Care
955
956 The program must assess the fellow in data
957 gathering, clinical reasoning, patient management
958 and procedures in both the inpatient and outpatient
959 setting. This assessment must involve direct
960 observation of fellow-patient encounters.
961

962	V.A. 1.b).(1).(a).(i)	<u>Each program must define a standard</u>
963		<u>criteria for proficiency competence for all</u>
964		<u>required and elective procedures.</u>
965		
966	V.A. 1.b).(1).(a).(ii)	<u>The record of evaluation must include the</u>
967		<u>fellow logbook or an equivalent method to</u>
968		<u>demonstrate that each fellow has achieved</u>
969		<u>competence in the performance of required</u>
970		<u>procedures.</u>
971		
972	V.A. 1.b).(1).(b)	<u>Medical Knowledge</u>
973		
974		<u>The program must use an objective formative</u>
975		<u>assessment method. The same formative</u>
976		<u>assessment method must be administered at least</u>
977		<u>twice during the program.</u>
978		
979	V.A. 1.b).(1).(c)	<u>Practice-based Learning and Improvement</u>
980		
981		<u>The program must use performance data to assess</u>
982		<u>fellow in:</u>
983		
984	V.A. 1.b).(1).(c).(i)	<u>application of evidence to patient care;</u>
985		
986	V.A. 1.b).(1).(c).(ii)	<u>practice improvement;</u>
987		
988	V.A. 1.b).(1).(c).(iii)	<u>teaching skills involving peers and patients;</u>
989		<u>and,</u>
990		
991	V.A. 1.b).(1).(c).(iv)	<u>scholarship.</u>
992		
993	V.A. 1.b).(1).(d)	<u>Interpersonal and Communication Skills</u>
994		
995		<u>The program must use both direct observation and</u>
996		<u>multi-source evaluation, including patients, peers</u>
997		<u>and non-physician team members, to assess fellow</u>
998		<u>performance in:</u>
999		
1000	V.A. 1.b).(1).(d).(i)	<u>communication with patient and family;</u>
1001		
1002	V.A. 1.b).(1).(d).(ii)	<u>teamwork;</u>
1003		
1004	V.A. 1.b).(1).(d).(iii)	<u>communication with peers, including</u>
1005		<u>transitions in care; and,</u>
1006		
1007	V.A. 1.b).(1).(d).(iv)	<u>record keeping.</u>
1008		
1009	V.A. 1.b).(1).(e)	<u>Professionalism</u>
1010		
1011		<u>The program must use multi-source evaluation,</u>
1012		<u>including patients, peers, and non-physician team</u>

1013		<u>members, to assess the fellow's:</u>
1014		
1015	V.A. 1.b).(1).(e).(i)	<u>honesty and integrity;</u>
1016		
1017	V.A. 1.b).(1).(e).(ii)	<u>ability to meet professional responsibilities;</u>
1018		
1019	V.A. 1.b).(1).(e).(iii)	<u>ability to maintain appropriate professional</u>
1020		<u>relationships with patients and colleagues;</u>
1021		<u>and.</u>
1022		
1023	V.A. 1.b).(1).(e).(iv)	<u>commitment to self-improvement.</u>
1024		
1025	V.A. 1.b).(1).(f)	<u>Systems-based Practice</u>
1026		
1027		<u>The program must use multi-source evaluation,</u>
1028		<u>including peers, and non-physician team members,</u>
1029		<u>to assess the fellow's:</u>
1030		
1031	V.A. 1.b).(1).(f).(i)	<u>ability to provide care coordination,</u>
1032		<u>including transition of care;</u>
1033		
1034	V.A. 1.b).(1).(f).(ii)	<u>ability to work in interdisciplinary teams;</u>
1035		
1036	V.A. 1.b).(1).(f).(iii)	<u>advocacy for quality of care; and,</u>
1037		
1038	V.A. 1.b).(1).(f).(iv)	<u>ability to identify system problems and</u>
1039		<u>participate in improvement activities.</u>
1040		
1041	V.A.1.b).(2)	use multiple evaluators (e.g., faculty, peers, patients,
1042		self, and other professional staff);
1043		
1044	V.A.1.b).(3)	document progressive fellow performance
1045		improvement appropriate to educational level; and
1046		
1047	V.A.1.b).(4)	provide each fellow with documented semiannual
1048		evaluation of performance with feedback.
1049		
1050	V.A.1.b).(4).(a)	<i>Fellows' performance in continuity clinic must be</i>
1051		<i>reviewed with them verbally and in writing at least</i>
1052		<i>semiannually.</i>
1053		
1054	V.A.1.c)	The evaluations of fellow performance must be accessible for
1055		review by the fellow, in accordance with institutional policy.
1056		
1057	V.A.2.	Summative Evaluation
1058		
1059		The program director must provide a summative evaluation for each
1060		fellow upon completion of the program. This evaluation must
1061		become part of the fellow's permanent record maintained by the
1062		institution, and must be accessible for review by the fellow in
1063		accordance with institutional policy. This evaluation must:

- 1064
- 1065 **V.A.2.a)** document the fellow's performance during the final period of
- 1066 education; and,
- 1067
- 1068 **V.A.2.b)** verify that the fellow has demonstrated sufficient competence
- 1069 to enter practice without direct supervision.
- 1070
- 1071 **V.B. Faculty Evaluation**
- 1072
- 1073 **V.B.1.** At least annually, the program must evaluate faculty performance as
- 1074 it relates to the educational program.
- 1075
- 1076 **V.B.2.** These evaluations should include a review of faculty's clinical
- 1077 teaching abilities, commitment to the educational program, clinical
- 1078 knowledge, professionalism, and scholarly activities.
- 1079
- 1080 **V.B.3.** This evaluation must include at least annual written confidential
- 1081 evaluations by fellows.
- 1082
- 1083 *V.B.3.a) ~~In addition, Fellows must have the opportunity to provide~~*
- 1084 *~~confidential written evaluations of each supervising faculty~~*
- 1085 *~~member teaching attending at the end of a each rotation.~~*
- 1086
- 1087 *V.B.3.b) ~~The program director must be reviewed. These evaluations must~~*
- 1088 *~~be reviewed with each attending faculty member annually.~~*
- 1089
- 1090 **V.C. Program Evaluation and Improvement**
- 1091
- 1092 **V.C.1.** The program must document formal, systematic evaluation of the
- 1093 curriculum at least annually. The program must monitor and track
- 1094 each of the following areas:
- 1095
- 1096 **V.C.1.a)** fellow performance;
- 1097
- 1098 **V.C.1.b)** faculty development;
- 1099
- 1100 **V.C.1.c)** graduate performance, including performance of program
- 1101 graduates on the certification examination; and,
- 1102
- 1103 *V.C.1.c).(1) ~~At least 80% of those eligible to take an ABIM subspecialty~~*
- 1104 *~~At least 80% of program's graduating fellows from those~~*
- 1105 *~~eligible to take an ABIM subspecialty certifying~~*
- 1106 *~~examination upon completion of their training for the most~~*
- 1107 *~~recently defined five year period who are eligible should~~*
- 1108 *~~must have taken an the ABIM subspecialty certifying~~*
- 1109 *~~examination. (Note: Five-year rolling pass rate for first time~~*
- 1110 *~~takers of the ABIM certifying examination will be examined~~*
- 1111 *~~at each program review).~~*
- 1112
- 1113 *V.C.1.c).(2) At least 80% of a program's graduates taking the ABIM*

certifying examination for the first time during the most recently defined five year period should pass.

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V.C.1.d)

program quality. Specifically:

V.C.1.d).(1)

Fellows and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually.

V.C.1.d).(2)

The program must use the results of fellows' assessments of the program together with other program evaluation results to improve the program.

V.C.1.d).(3)

At least 80% of the entering fellows should have completed the program when averaged over a five-year period.

V.C.2.

If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

V.C.3.

Representative program personnel, at a minimum to include the program director, representative faculty, and one fellow, must review program goals and objectives, and the effectiveness with which they are achieved.

VI. Fellow Duty Hours in the Learning and Working Environment

VI.A.

Professionalism, Personal Responsibility, and Patient Safety

VI.A.1.

Programs and sponsoring institutions must educate fellows and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.

VI.A.2.

The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational environment.

VI.A.3.

The program director must ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

VI.A.4.

The learning objectives of the program must:

VI.A.4.a)

be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,

- 1164 **VI.A.4.b)** **not be compromised by excessive reliance on fellows to fulfill**
 1165 **non-physician service obligations.**
 1166
 1167 ~~VI.A.4.b).(1)~~ ~~Fellows' service responsibilities must be limited to patients~~
 1168 ~~for whom the teaching service has diagnostic and~~
 1169 ~~therapeutic responsibility.~~
 1170
 1171 **VI.A.5.** **The program director and institution must ensure a culture of**
 1172 **professionalism that supports patient safety and personal**
 1173 **responsibility. Fellows and faculty members must demonstrate an**
 1174 **understanding and acceptance of their personal role in the**
 1175 **following:**
 1176
 1177 **VI.A.5.a)** **assurance of the safety and welfare of patients entrusted to**
 1178 **their care;**
 1179
 1180 **VI.A.5.b)** **provision of patient- and family-centered care;**
 1181
 1182 **VI.A.5.c)** **assurance of their fitness for duty;**
 1183
 1184 **VI.A.5.d)** **management of their time before, during, and after clinical**
 1185 **assignments;**
 1186
 1187 **VI.A.5.e)** **recognition of impairment, including illness and fatigue, in**
 1188 **themselves and in their peers;**
 1189
 1190 **VI.A.5.f)** **attention to lifelong learning;**
 1191
 1192 **VI.A.5.g)** **the monitoring of their patient care performance improvement**
 1193 **indicators; and,**
 1194
 1195 **VI.A.5.h)** **honest and accurate reporting of duty hours, patient**
 1196 **outcomes, and clinical experience data.**
 1197
 1198 **VI.A.6.** **All fellows and faculty members must demonstrate responsiveness**
 1199 **to patient needs that supersedes self-interest. Physicians must**
 1200 **recognize that under certain circumstances, the best interests of the**
 1201 **patient may be served by transitioning that patient's care to another**
 1202 **qualified and rested provider.**
 1203
 1204 **VI.B.** **Transitions of Care**
 1205
 1206 **VI.B.1.** **Programs must design clinical assignments to minimize the number**
 1207 **of transitions in patient care.**
 1208
 1209 **VI.B.2.** **Sponsoring institutions and programs must ensure and monitor**
 1210 **effective, structured hand-over processes to facilitate both**
 1211 **continuity of care and patient safety.**
 1212
 1213 **VI.B.3.** **Programs must ensure that fellows are competent in communicating**

- 1214 with team members in the hand-over process.
- 1215
- 1216 **VI.B.4.** The sponsoring institution must ensure the availability of schedules
- 1217 that inform all members of the health care team of attending
- 1218 physicians and fellows currently responsible for each patient's care.
- 1219
- 1220 **VI.C.** Alertness Management/Fatigue Mitigation
- 1221
- 1222 **VI.C.1.** The program must:
- 1223
- 1224 **VI.C.1.a)** educate all faculty members and fellows to recognize the
- 1225 signs of fatigue and sleep deprivation;
- 1226
- 1227 **VI.C.1.b)** educate all faculty members and fellows in alertness
- 1228 management and fatigue mitigation processes; and,
- 1229
- 1230 **VI.C.1.c)** adopt fatigue mitigation processes to manage the potential
- 1231 negative effects of fatigue on patient care and learning, such
- 1232 as naps or back-up call schedules.
- 1233
- 1234 **VI.C.2.** Each program must have a process to ensure continuity of patient
- 1235 care in the event that a fellow may be unable to perform his/her
- 1236 patient care duties.
- 1237
- 1238 **VI.C.3.** The sponsoring institution must provide adequate sleep facilities
- 1239 and/or safe transportation options for fellows who may be too
- 1240 fatigued to safely return home.
- 1241
- 1242 **VI.D.** Supervision of Fellows
- 1243
- 1244 **VI.D.1.** In the clinical learning environment, each patient must have an
- 1245 identifiable, appropriately-credentialed and privileged attending
- 1246 physician (or licensed independent practitioner as approved by each
- 1247 Review Committee) who is ultimately responsible for that patient's
- 1248 care.
- 1249
- 1250 **VI.D.1.a)** This information should be available to fellows, faculty
- 1251 members, and patients.
- 1252
- 1253 **VI.D.1.b)** Fellows and faculty members should inform patients of their
- 1254 respective roles in each patient's care.
- 1255
- 1256 **VI.D.2.** The program must demonstrate that the appropriate level of
- 1257 supervision is in place for all fellows who care for patients.
- 1258
- 1259 Supervision may be exercised through a variety of methods. Some
- 1260 activities require the physical presence of the supervising faculty
- 1261 member. For many aspects of patient care, the supervising
- 1262 physician may be a more advanced resident or fellow. Other
- 1263 portions of care provided by the fellow can be adequately

1264 supervised by the immediate availability of the supervising faculty
1265 member or resident physician, either in the institution, or by means
1266 of telephonic and/or electronic modalities. In some circumstances,
1267 supervision may include post-hoc review of fellow-delivered care
1268 with feedback as to the appropriateness of that care.
1269

1270 **VI.D.3. Levels of Supervision**

1271
1272 To ensure oversight of fellow supervision and graded authority and
1273 responsibility, the program must use the following classification of
1274 supervision:

1275
1276 **VI.D.3.a) Direct Supervision – the supervising physician is physically**
1277 **present with the fellow and patient.**

1278
1279 **VI.D.3.b) Indirect Supervision:**

1280
1281 **VI.D.3.b).(1) with direct supervision immediately available – the**
1282 **supervising physician is physically within the hospital**
1283 **or other site of patient care, and is immediately**
1284 **available to provide Direct Supervision.**

1285
1286 **VI.D.3.b).(2) with direct supervision available – the supervising**
1287 **physician is not physically present within the hospital**
1288 **or other site of patient care, but is immediately**
1289 **available by means of telephonic and/or electronic**
1290 **modalities, and is available to provide Direct**
1291 **Supervision.**

1292
1293 **VI.D.3.c) Oversight – the supervising physician is available to provide**
1294 **review of procedures/encounters with feedback provided**
1295 **after care is delivered.**

1296
1297 **VI.D.4. The privilege of progressive authority and responsibility, conditional**
1298 **independence, and a supervisory role in patient care delegated to**
1299 **each fellow must be assigned by the program director and faculty**
1300 **members.**

1301
1302 **VI.D.4.a) The program director must evaluate each fellow’s abilities**
1303 **based on specific criteria. When available, evaluation should**
1304 **be guided by specific national standards-based criteria.**

1305
1306 **VI.D.4.b) Faculty members functioning as supervising physicians**
1307 **should delegate portions of care to fellows, based on the**
1308 **needs of the patient and the skills of the fellows.**

1309
1310 **VI.D.4.c) Senior residents or fellows should serve in a supervisory role**
1311 **of junior residents in recognition of their progress toward**
1312 **independence, based on the needs of each patient and the**
1313 **skills of the individual resident or fellow.**

1314
1315 **VI.D.5.** **Programs must set guidelines for circumstances and events in**
1316 **which fellows must communicate with appropriate supervising**
1317 **faculty members, such as the transfer of a patient to an intensive**
1318 **care unit, or end-of-life decisions.**
1319
1320 **VI.D.5.a)** **Each fellow must know the limits of his/her scope of**
1321 **authority, and the circumstances under which he/she is**
1322 **permitted to act with conditional independence.**
1323
1324 **VI.D.5.a).(1)** **In particular, PGY-1 residents should be supervised**
1325 **either directly or indirectly with direct supervision**
1326 **immediately available.**
1327
1328 **VI.D.6.** **Faculty supervision assignments should be of sufficient duration to**
1329 **assess the knowledge and skills of each fellow and delegate to**
1330 **him/her the appropriate level of patient care authority and**
1331 **responsibility.**
1332
1333 **VI.E.** **Clinical Responsibilities**
1334
1335 **The clinical responsibilities for each fellow must be based on PGY-level,**
1336 **patient safety, fellow education, severity and complexity of patient**
1337 **illness/condition and available support services.**
1338
1339 **VI.F.** **Teamwork**
1340
1341 **Fellows must care for patients in an environment that maximizes effective**
1342 **communication. This must include the opportunity to work as a member of**
1343 **effective interprofessional teams that are appropriate to the delivery of care**
1344 **in the specialty.**
1345
1346 **VI.G.** **Fellow Duty Hours**
1347
1348 **VI.G.1.** **Maximum Hours of Work per Week**
1349
1350 **Duty hours must be limited to 80 hours per week, averaged over a**
1351 **four-week period, inclusive of all in-house call activities and all**
1352 **moonlighting.**
1353
1354 **VI.G.1.a)** **Duty Hour Exceptions**
1355
1356 **A Review Committee may grant exceptions for up to 10% or a**
1357 **maximum of 88 hours to individual programs based on a**
1358 **sound educational rationale.**
1359
1360 *The Review Committee for Internal Medicine will not consider*
1361 *requests for exceptions to the 80-hour limit to the fellows' work*
1362 *week.*
1363

- 1364 **VI.G.1.a).(1)** In preparing a request for an exception the program
1365 director must follow the duty hour exception policy
1366 from the ACGME Manual on Policies and Procedures.
1367
- 1368 **VI.G.1.a).(2)** Prior to submitting the request to the Review
1369 Committee, the program director must obtain approval
1370 of the institution's GMEC and DIO.
1371
- 1372 **VI.G.2.** **Moonlighting**
- 1373
- 1374 **VI.G.2.a)** Moonlighting must not interfere with the ability of the fellow
1375 to achieve the goals and objectives of the educational
1376 program.
1377
- 1378 **VI.G.2.b)** Time spent by fellows in Internal and External Moonlighting
1379 (as defined in the ACGME Glossary of Terms) must be
1380 counted towards the 80-hour Maximum Weekly Hour Limit.
1381
- 1382 **VI.G.2.c)** PGY-1 residents are not permitted to moonlight.
1383
- 1384 **VI.G.3.** **Mandatory Time Free of Duty**
- 1385
- 1386 Fellows must be scheduled for a minimum of one day free of duty
1387 every week (when averaged over four weeks). At-home call cannot
1388 be assigned on these free days.
1389
- 1390 **VI.G.4.** **Maximum Duty Period Length**
- 1391
- 1392 **VI.G.4.a)** Duty periods of PGY-1 residents must not exceed 16 hours in
1393 duration.
1394
- 1395 **VI.G.4.b)** Duty periods of PGY-2 residents and above may be
1396 scheduled to a maximum of 24 hours of continuous duty in
1397 the hospital. Programs must encourage fellows to use
1398 alertness management strategies in the context of patient
1399 care responsibilities. Strategic napping, especially after 16
1400 hours of continuous duty and between the hours of 10:00
1401 p.m. and 8:00 a.m., is strongly suggested.
1402
- 1403 **VI.G.4.b).(1)** It is essential for patient safety and fellow education
1404 that effective transitions in care occur. Fellows may be
1405 allowed to remain on-site in order to accomplish these
1406 tasks; however, this period of time must be no longer
1407 than an additional four hours.
1408
- 1409 **VI.G.4.b).(2)** Fellows must not be assigned additional clinical
1410 responsibilities after 24 hours of continuous in-house
1411 duty.
1412
- 1413 **VI.G.4.b).(3)** In unusual circumstances, fellows, on their own

1414 initiative, may remain beyond their scheduled period
1415 of duty to continue to provide care to a single patient.
1416 Justifications for such extensions of duty are limited
1417 to reasons of required continuity for a severely ill or
1418 unstable patient, academic importance of the events
1419 transpiring, or humanistic attention to the needs of a
1420 patient or family.

1421
1422 **VI.G.4.b).(3).(a)** Under those circumstances, the fellow must:

1423
1424 **VI.G.4.b).(3).(a).(i)** appropriately hand over the care of all
1425 other patients to the team responsible
1426 for their continuing care; and,

1427
1428 **VI.G.4.b).(3).(a).(ii)** document the reasons for remaining to
1429 care for the patient in question and
1430 submit that documentation in every
1431 circumstance to the program director.

1432
1433 **VI.G.4.b).(3).(b)** The program director must review each
1434 submission of additional service, and track
1435 both individual fellow and program-wide
1436 episodes of additional duty.

1437
1438 **VI.G.5.** Minimum Time Off between Scheduled Duty Periods

1439
1440 **VI.G.5.a)** PGY-1 residents should have 10 hours, and must have eight
1441 hours, free of duty between scheduled duty periods.

1442
1443 **VI.G.5.b)** Intermediate-level residents should have 10 hours free of
1444 duty, and must have eight hours between scheduled duty
1445 periods. They must have at least 14 hours free of duty after 24
1446 hours of in-house duty.

1447
1448 *Internal medicine subspecialty fellows are considered to be in the*
1449 *final years of education.*

1450
1451 **VI.G.5.c)** Residents in the final years of education must be prepared to
1452 enter the unsupervised practice of medicine and care for
1453 patients over irregular or extended periods.

1454
1455 *Internal medicine subspecialty fellows are considered to be in the*
1456 *final years of education.*

1457
1458 **VI.G.5.c).(1)** This preparation must occur within the context of the
1459 80-hour, maximum duty period length, and one-day-
1460 off-in-seven standards. While it is desirable that
1461 fellows in their final years of education have eight
1462 hours free of duty between scheduled duty periods,
1463 there may be circumstances when these fellows must

1464 stay on duty to care for their patients or return to the
1465 hospital with fewer than eight hours free of duty.

1466
1467 **VI.G.5.c).(1).(a)**

Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by fellows in their final years of education must be monitored by the program director.

1472
1473 *VI.G.5.c).(1).(b)*

In unusual circumstances, fellows may remain beyond their scheduled period of duty or return after their scheduled period of duty to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of the patient or family. Such episodes should be rare, must be of the fellows' own initiative, and need not initiate a new 'off-duty period' nor require a change in the scheduled 'off-duty period.'

1486
1487 *VI.G.5.c).(1).(c)*

Under such circumstances, the fellow must appropriately hand over care of all other patients to the team responsible for their continuing care, and document the reasons for remaining or returning to care for the patient in question and submit that documentation to the program director.

1492
1493 *VI.G.5.c).(1).(d)*

The program director must review each submission of additional service and track both individual fellows' and program-wide episodes of additional duty.

1498
1499 **VI.G.6.**

Maximum Frequency of In-House Night Float

1500
1501 **Fellows must not be scheduled for more than six consecutive nights**
1502 **of night float.**

1503
1504 **VI.G.7.**

Maximum In-House On-Call Frequency

1505
1506 **PGY-2 residents and above must be scheduled for in-house call no**
1507 **more frequently than every-third-night (when averaged over a four-**
1508 **week period).**

1509
1510 *VI.G.7.a)*

*Internal Medicine ~~residency programs are~~ fellowships must not
1511 allowed to average in-house call over a four-week period.*

1512
1513 **VI.G.8.**

At-Home Call

1515 **VI.G.8.a)** Time spent in the hospital by fellows on at-home call must
1516 count towards the 80-hour maximum weekly hour limit. The
1517 frequency of at-home call is not subject to the every-third-
1518 night limitation, but must satisfy the requirement for one-day-
1519 in-seven free of duty, when averaged over four weeks.

1520
1521 **VI.G.8.a).(1)** At-home call must not be so frequent or taxing as to
1522 preclude rest or reasonable personal time for each
1523 fellow.

1524
1525 **VI.G.8.b)** Fellows are permitted to return to the hospital while on at-
1526 home call to care for new or established patients. Each
1527 episode of this type of care, while it must be included in the
1528 80-hour weekly maximum, will not initiate a new “off-duty
1529 period”.

1530
1531 **VII. Innovative Projects**

1532
1533 Requests for innovative projects that may deviate from the institutional, common
1534 and/or specialty specific program requirements must be approved in advance by
1535 the Review Committee. In preparing requests, the program director must follow
1536 Procedures for Approving Proposals for Innovative Projects located in the ACGME
1537 Manual on Policies and Procedures. Once a Review Committee approves a
1538 project, the sponsoring institution and program are jointly responsible for the
1539 quality of education offered to fellows for the duration of such a project.

1540
1541 ***

1542
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