

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Medical Oncology (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~~ **Medical oncology 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~~ **The educational program accredited fellowship in medical oncology 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. A medical oncology fellowship must function as an integral part of an
- 54 ACGME-accredited residency program in internal medicine.
- 55
- 56 I.A.2. *The sponsoring institution must:*
- 57
- 58 I.A.2.a) establish the medical oncology 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 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 the two-year per year; and each~~
- 98 ~~training program that do not number less than the number of~~
- 99 ~~accredited training years in the 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 medical
151 oncology fellowship .

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;**
156
157 **II.A.3.b).(1)** The Review Committee only accepts current ABIM
158 certification in medical oncology.
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 *internal medicine residency program to ensure compliance with*
- 297 *~~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
327 **II.B.5.** The faculty must establish and maintain an environment of inquiry
328 and scholarship with an active research component.

329
330 **II.B.5.a)** The faculty must regularly participate in organized clinical
331 discussions, rounds, journal clubs, and conferences.

332
333 **II.B.5.b)** Some members of the faculty should also demonstrate
334 scholarship by one or more of the following:

335
336 **II.B.5.b).(1)** peer reviewed funding;

337
338 **II.B.5.b).(2)** publication of original research or review articles in
339 peer reviewed journals or chapters in textbooks;

340
341 **II.B.5.b).(3)** publication or presentation of case reports or clinical
342 series at local, regional, or national professional and
343 scientific society meetings; or,

344
345 **II.B.5.b).(4)** participation in national committees or educational
346 organizations.

347
348 **II.B.5.c)** Faculty should encourage and support fellows in scholarly
349 activities.

350
351 **II.B.6.** *The physician faculty must meet professional standards of ethical*
352 *behavior.*

353

- 354 II.B.7. Key Clinical Faculty
355
356 In addition to the program director, each program must have at least two
357 Key Clinical Faculty (KCF). KCF are attending physicians who dedicate,
358 on average, 10 hours per week throughout the year to the ~~training~~
359 program. For programs with more than four fellows, ~~enrolled during the~~
360 ~~accredited portion of the training program, a ratio of key clinical faculty to~~
361 ~~fellows of at least 1 there must be at least one KCF for every 1.5~~
362 ~~fellows must be maintained.~~
- 363
364 II.B.7.a) Key Clinical Faculty Qualifications
365
366 II.B.7.a).(1) KCF must be active clinicians with ~~broad~~ knowledge of,
367 experience with, and commitment to medical oncology as a
368 discipline.
369
370 II.B.7.a).(2) KCF must have current ABIM certification in medical
371 oncology.
372
373 *II.B.7.b) Key Clinical Faculty Responsibilities*
374
375 *II.B.7.b).(1) In addition to the responsibilities of all individual faculty*
376 *members, the KCF ~~with and~~ the program director are*
377 *responsible for the planning, implementation, monitoring*
378 *and evaluation of the fellows' clinical and research*
379 *education ~~training~~.*
380
381 *II.B.7.b).(2) ~~The majority~~ At least 50 % of the key clinical faculty(KCF)*
382 *must demonstrate evidence of productivity in the*
383 *scholarship, specifically, peer-reviewed funding;*
384 *publication of original research, review articles, editorials,*
385 *or case reports in peer-reviewed journals; or chapters in*
386 *textbooks. ~~as defined in II.B.5.b.(1), or (2) above.~~*
387
388 *II.B.7.b).(3) At least one KCF must:*
389
390 *II.B.7.b).(3).(a) be knowledgeable in the evaluation and*
391 *assessment of the ACGME 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.B.9. Faculty members who are subspecialty certified by the ~~American Board of~~

405 ~~Internal Medicine ABIM-certified~~ in endocrinology, gastroenterology,
406 hematology, infectious disease, nephrology, and pulmonary disease ~~must~~
407 should be available to participate in the education of fellows in ~~medical-~~
408 ~~oncology~~.

409
410 **II.C. Other Program Personnel**

411
412 **The institution and the program must jointly ensure the availability of all**
413 **necessary professional, technical, and clerical personnel for the effective**
414 **administration the program.**

415
416 *II.C.1. There must be services available from other health care professionals,*
417 *including dietitians, language interpreters, nurses, occupational*
418 *therapists, physical therapists, and social workers.*

419
420 *II.C.2. The fellowship must have access to surgeons in general surgery and*
421 *surgical specialties, including surgeons those with special interest in*
422 *oncology ~~must be available to participate in the education of fellows in~~*
423 *~~hematology and oncology.~~*

424
425 *II.C.3. The ~~program fellowship~~ also must have access to other clinical*
426 *specialists, specifically including specialists in dermatology, gynecology,*
427 *neurology, ~~neurosurgery~~ neurological surgery, orthopedics,*
428 *otolaryngology, and urology.*

429
430 *II.C.4. There must be the availability of appropriate and timely consultation from*
431 *other specialties.*

432
433 *II.C.5. ~~The following~~ Expertise and in the following disciplines should be*
434 *available to the ~~training~~ program to provide multidisciplinary patient care*
435 *and fellow education:*

436
437 *II.C.5.a) genetic counseling;*

438
439 *II.C.5.b) hospice and palliative care;*

440
441 *II.C.5.c) oncologic nursing;*

442
443 *II.C.5.d) pain management;*

444
445 *II.C.5.e) psychiatry; and,*

446
447 *II.C.5.f) rehabilitation medicine.*

448
449 *II.C.5.g) dietetics;*

450
451 *II.C.5.h) ~~social services;~~*

452
453 **II.D. Resources**

454
455 **The institution and the program must jointly ensure the availability of**

456 **adequate resources for fellow education, as defined in the specialty**
457 **program requirements.**
458
459 *II.D.1. Space and Equipment*
460
461 *There must be space and equipment for the ~~educational~~ program,*
462 *including meeting rooms, ~~classrooms~~, examination rooms, computers,*
463 *visual and other educational aids, and work/study space.*
464
465 *II.D.2. Facilities*
466
467 *II.D.2.a) Inpatient and outpatient systems must be in place to prevent*
468 *fellows from performing routine clerical functions, including*
469 *scheduling tests and appointments, and retrieving records and*
470 *letters.*
471
472 *II.D.2.b) The sponsoring institution must provide the broad range of*
473 *facilities and clinical support services required to provide*
474 *comprehensive care of adult patients. ~~Fellows must have clinical~~*
475 *experiences in efficient, effective ambulatory and inpatient care*
476 *settings.*
477
478 *II.D.2.c) Fellows must have access to a lounge facility during assigned*
479 *duty hours.*
480
481 *II.D.2.d) When fellows are ~~assigned night duty~~ in the hospital, assigned*
482 *night duty, or called in from home, they must be provided with ~~on-~~*
483 *call facilities that are convenient and that afford privacy, safety,*
484 *and a restful environment with a secure space for their*
485 *belongings.*
486
487 *II.D.2.e) Radiation oncology facilities must be available. ~~at the primary~~*
488 *~~training site.~~*
489
490 *II.D.3. Laboratory and Imaging Services*
491
492 *II.D.3.a) A hematology laboratory must be located at the primary ~~training~~*
493 *clinical site.*
494
495 *II.D.3.b) A specialized coagulation laboratory must be accessible. ~~present~~*
496 *~~at the primary training site or affiliated institution(s).~~*
497
498 *II.D.3.c) The following must be present at the primary clinical site or*
499 *participating site(s):*
500
501 *II.D.3.c).(1) nuclear medicine imaging; ~~must be accessible for the~~*
502 *~~training program.~~*
503
504 *I.A.1.a).(1) cross-sectional imaging, including coaxial tomography*
505 *(CT) and magnetic resonance imaging (MRI); and,*
506

507 I.A.1.a).(2) positron emission tomography (PET) scan imaging.
508
509 II.D.4. Other Facilities, Resources, or Support Services
510
511 II.D.4.a) There must be advanced pathology services ~~must be available,~~
512 including:
513
514 II.D.4.a).(1) immunopathology;
515
516 II.D.4.a).(2) blood banking; and,
517
518 II.D.4.a).(3) transfusion and apheresis ~~facilities must be available at the~~
519 primary training site.
520
521 II.D.4.b) There must be a hematology clinical program with which medical
522 oncology fellows may interact.
523
524 II.D.5. *Medical Records*
525
526 Access to an electronic health record should be provided. In the absence
527 of an existing electronic health record, institutions must demonstrate
528 institutional commitment to its development, and progress towards its
529 implementation.
530
531 II.D.6. Patient Population
532
533 II.D.6.a) The patient population must have a variety of clinical problems
534 and stages of diseases.
535
536 II.D.6.b) *There must be patients of each ~~both sexes~~ gender, with a broad*
537 *age range, including geriatric patients.*
538
539 II.D.6.c) *A sufficient number of patients must be available to enable ~~ensure~~*
540 *adequate inpatient and ambulatory experience for each fellow to*
541 *achieve the required educational outcomes.*
542
543 **II.E. Medical Information Access**
544
545 **Fellows must have ready access to specialty-specific and other appropriate**
546 **reference material in print or electronic format. Electronic medical literature**
547 **databases with search capabilities should be available.**
548
549 **III. Fellow Appointments**
550
551 **III.A. Eligibility Criteria**
552
553 **The program director must comply with the criteria for fellow eligibility as**
554 **specified in the Institutional Requirements.**
555
556 I.A.1. *Prior to appointment in the fellowship ~~program~~, fellows should have*
557 *completed an ACGME-accredited internal medicine ~~education~~ program.*

- 558
559 I.A.2. *Fellows from non-ACGME-accredited internal medicine ~~education~~*
560 *programs must have completed at least three years of internal medicine*
561 *education prior to starting the fellowship.*
562
563 I.A.3. *The program director must inform ~~non-ACGME trained~~ applicants from*
564 *non-ACGME-accredited programs, prior to appointment, and in writing, of*
565 *the ABIM policies and procedures that ~~may~~ will affect the fellow's their*
566 *eligibility for ABIM certification.*
567
568 I.A.4. *When averaged over any five-year period, a minimum of 75% of fellows in*
569 *each ~~subspecialty training~~ program must be graduates of an ACGME-*
570 *accredited internal medicine ~~training program~~. ~~Non-ACGME internal~~*
571 *medicine trained fellows must have at least three years of internal*
572 *medicine ~~training~~ prior to starting fellowship.*
573
574 **III.B. Number of Fellows**
575
576 **The program director may not appoint more fellows than approved by the**
577 **Review Committee, unless otherwise stated in the specialty-specific**
578 **requirements. The program's educational resources must be adequate to**
579 **support the number of fellows appointed to the program.**
580
581 III.B.1. *The ~~minimum~~ number of available fellow positions in the ~~training~~ program*
582 *must be at least one per year ~~not be less than the number of accredited~~*
583 *~~training years in the program.~~*
584
585 **III.C. Fellow Transfers**
586
587 **III.C.1. Before accepting a fellow who is transferring from another program,**
588 **the program director must obtain written or electronic verification of**
589 **previous educational experiences and a summative competency-**
590 **based performance evaluation of the transferring fellow.**
591
592 **III.C.2. A program director must provide timely verification of fellowship**
593 **education and summative performance evaluations for fellows who**
594 **leave the program prior to completion.**
595
596 **III.D. Appointment of Fellows and Other Learners**
597
598 **The presence of other learners (including, but not limited to, residents from**
599 **other specialties, subspecialty fellows, PhD students, and nurse**
600 **practitioners) in the program must not interfere with the appointed fellows'**
601 **education. The program director must report the presence of other learners**
602 **to the DIO and GMEC in accordance with sponsoring institution guidelines.**
603
604 **IV. Educational Program**
605
606 **IV.A. The curriculum must contain the following educational components:**
607

- 608 **IV.A.1.** Overall educational goals for the program, which the program must
609 distribute to fellows and faculty annually;
610
- 611 **IV.A.2.** Competency-based goals and objectives for each assignment at
612 each educational level, which the program must distribute to fellows
613 and faculty annually, in either written or electronic form. These
614 should be reviewed by the fellow at the start of each rotation;
615
- 616 **IV.A.3.** Regularly scheduled didactic sessions;
617
- 618 IV.A.3.a) The core curriculum must include a didactic program based upon
619 the core knowledge content in the subspecialty area.
620
- 621 IV.A.3.a).(1) The program must afford each fellow an opportunity to
622 review topics covered in conferences that he or she was
623 unable to attend.
624
- 625 IV.A.3.a).(2) Fellows must participate in clinical case conferences,
626 journal clubs, research conferences, and morbidity and
627 mortality or quality improvement conferences.
628
- 629 IV.A.3.a).(3) All core conferences must have at least one faculty
630 member present, and must be scheduled as to ensure
631 peer-peer and peer-faculty interaction.
632
- 633 IV.A.3.b) Patient-based teaching must include direct interaction between
634 fellows and ~~attending~~ faculty members, bedside teaching,
635 discussion of pathophysiology, and the use of current evidence in
636 diagnostic and therapeutic decisions. The teaching must be:
637
- 638 IV.A.3.b).(1) formally conducted on all inpatient, outpatient, and
639 consultative services; and,
640
- 641 IV.A.3.b).(2) conducted with a frequency and duration sufficient to that
642 ensures a meaningful and continuous teaching relationship
643 between the assigned supervising faculty member(s)-
644 teaching attending and fellows.
645
- 646 IV.A.3.c) Fellows must receive instruction in practice management relevant
647 to medical oncology.
648
- 649 **IV.A.4.** Delineation of fellow responsibilities for patient care, progressive
650 responsibility for patient management, and supervision of fellows
651 over the continuum of the program.
652
- 653 **IV.A.5.** ACGME Competencies
654
- 655 The program must integrate the following ACGME competencies
656 into the curriculum:
657
- 658 **IV.A.5.a) Patient Care**

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

IV.A.5.a).(1)

must demonstrate competence in the practice of health promotion, disease prevention, diagnosis, care, and treatment of ~~men and women~~ patients of each gender, from adolescence to old age, during health and all stages of illness;

IV.A.5.a).(2)

must demonstrate competence as a consultant in medical oncology disorders and assume continuing responsibility for acutely- and chronically-ill patients in both inpatient and outpatient settings, the natural history of cancer, and the benefits and adverse effects of therapy;

IV.A.5.a).(3)

~~must have formal instruction, clinical experience, and demonstrate competence in the:~~

IV.A.5.a).(3).(a)

prevention, evaluation, diagnosis, cancer staging, and management of patients with neoplastic disorders of the:

IV.A.5.a).(3).(a).(i)

lung;

IV.A.5.a).(3).(a).(ii)

gastrointestinal tract (esophagus, stomach, colon, rectum, anus);

IV.A.5.a).(3).(a).(iii)

breast;

IV.A.5.a).(3).(a).(iv)

pancreas;

IV.A.5.a).(3).(a).(v)

liver;

IV.A.5.a).(3).(a).(vi)

testes;

IV.A.5.a).(3).(a).(vii)

lymphoid organs;

IV.A.5.a).(3).(a).(viii)

hematopoietic system;

IV.A.5.a).(3).(a).(ix)

central nervous system;

IV.A.5.a).(3).(a).(x)

head and neck;

IV.A.5.a).(3).(a).(xi)

thyroid and other endocrine organs, including multiple endocrine neoplasia (MEN) syndromes;

IV.A.5.a).(3).(a).(xii)

skin, including melanoma;

710	IV.A.5.a).(3).(a).(xiii)	genitourinary tract;
711		
712	IV.A.5.a).(3).(a).(xiv)	cancer family syndromes; and,
713		
714	IV.A.5.a).(3).(a).(xv)	gynecologic malignancies.
715		
716	IV.A.5.a).(3).(b)	indications and application of imaging techniques in
717		patients with neoplastic and blood disorders;
718		
719	IV.A.5.a).(3).(c)	use of chemotherapeutic drugs, biologic products,
720		and growth factors, their mechanisms of action,
721		pharmacokinetics, clinical indications, and
722		limitations, including their effects, toxicity, and
723		interactions;
724		
725	IV.A.5.a).(3).(d)	use of multiagent chemotherapeutic protocols and
726		combined modality therapy of neoplastic disorders;
727		
728	IV.A.5.a).(3).(e)	management and care of indwelling access
729		catheters;
730		
731	IV.A.5.a).(3).(f)	role and use of hematologic, infectious disease,
732		and nutrition support;
733		
734	IV.A.5.a).(3).(g)	management of the neutropenic and the
735		immunocompromised patient;
736		
737	IV.A.5.a).(3).(h)	management of pain, anxiety, and depression in
738		patients with cancer;
739		
740	IV.A.5.a).(3).(i)	rehabilitation and psychosocial care of patients with
741		cancer;
742		
743	IV.A.5.a).(3).(j)	palliative care, including hospice and home care;
744		
745	IV.A.5.a).(3).(k)	treatment and diagnosis of recognition and
746		management of paraneoplastic disorders;
747		
748	IV.A.5.a).(3).(l)	specific cancer prevention and screening for high-
749		risk individuals, including competency in genetic
750		testing;
751		
752	IV.A.5.a).(3).(m)	care of patients with HIV-related malignancies;
753		
754	IV.A.5.a).(3).(n)	care and management of the geriatric patient with
755		malignancy and hematologic disorders;
756		
757	IV.A.5.a).(3).(o)	correlation of clinical information with cytology,
758		histology, and immunodiagnostic imaging
759		techniques;
760		

- 761 IV.A.5.a).(3).(p) use of chemotherapeutic agents and biological
762 products through all therapeutic routes;
763
- 764 IV.A.5.a).(3).(q) assessment of tumor burden and response as
765 measured by physical and radiologic exam, and
766 tumor markers;
767
- 768 IV.A.5.a).(3).(r) assessment of tumor imaging by ~~computed-~~
769 ~~tomography-CT, magnetic resonance-MRI, positron-~~
770 ~~emission tomography (PET) scanning, and nuclear~~
771 ~~imaging techniques;~~
772
- 773 IV.A.5.a).(3).(s) performance and interpretation of ~~the following-~~
774 complete blood count, including platelets and white
775 cell differential, by means of automated or manual
776 techniques, with appropriate quality control;
777
- 778 IV.A.5.a).(3).(t) performance and interpretation of bone marrow
779 aspiration and biopsy;
780
- 781 IV.A.5.a).(3).(u) preparation, staining, and interpretation of blood
782 smears, bone marrow aspirates, and touch
783 preparations;
784
- 785 IV.A.5.a).(3).(v) performance and interpretation of lumbar puncture
786 and interpretation of cerebrospinal fluid;
787
- 788 IV.A.5.a).(3).(w) access and care of Ommaya reservoir;
789
- 790 IV.A.5.a).(3).(x) intrathecal administration of chemotherapeutic
791 agents; and,
792
- 793 IV.A.5.a).(3).(y) care and management of venous access devices.
794

795 **IV.A.5.b)**

Medical Knowledge

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

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- 801
- 802 IV.A.5.b).(1) *must demonstrate knowledge of the scientific method of*
803 *problem solving and evidence-based decision making;*
804 *commitment to lifelong learning, and an attitude of caring-*
805 *that is derived from humanistic and professional values.*
- 806
- 807 IV.A.5.b).(2) *must ~~develop~~ demonstrate knowledge understanding of*
808 *indications, contraindications, limitations, complications,*
809 *techniques, and interpretation of results of those diagnostic*
810 *and therapeutic procedures integral to the discipline,*
811 *including the appropriate indication for and use of*

812		<u>screening tests/procedure;</u>
813		
814	IV.A.5.b).(3)	<u>must demonstrate knowledge of pathogenesis, diagnosis,</u>
815		<u>and treatment of disease, including;</u>
816		
817	IV.A.5.b).(3).(a)	basic molecular and pathophysiologic mechanisms,
818		diagnosis, and therapy of diseases of the blood,
819		including anemias, diseases of white blood cells
820		and stem cells, and disorders of hemostasis and
821		thrombosis; and,
822		
823	IV.A.5.b).(3).(b)	etiology, epidemiology, natural history, diagnosis,
824		pathology, staging, and management of neoplastic
825		diseases of the blood, blood-forming organs, and
826		lymphatic tissues.
827		
828	IV.A.5.b).(4)	<u>must demonstrate knowledge of genetics and</u>
829		<u>developmental biology, including;</u>
830		
831	IV.A.5.b).(4).(a)	molecular genetics;
832		
833	IV.A.5.b).(4).(b)	the nature of oncogenes and their products; and,
834		
835	IV.A.5.b).(4).(c)	cytogenetics.
836		
837	IV.A.5.b).(5)	<u>must demonstrate knowledge of physiology and</u>
838		<u>pathophysiology, including;</u>
839		
840	IV.A.5.b).(5).(a)	cell and molecular biology;
841		
842	IV.A.5.b).(5).(b)	hematopoiesis;
843		
844	IV.A.5.b).(5).(c)	principles of oncogenesis;
845		
846	IV.A.5.b).(5).(d)	tumor immunology;
847		
848	IV.A.5.b).(5).(e)	molecular mechanisms of hematopoietic and
849		lymphopoietic malignancies;
850		
851	IV.A.5.b).(5).(f)	basic and clinical pharmacology, pharmacokinetics,
852		and toxicity; and,
853		
854	IV.A.5.b).(5).(g)	pathophysiology and patterns of tumor metastases.
855		
856	IV.A.5.b).(6)	<u>must demonstrate knowledge of:</u>
857		
858	IV.A.5.b).(6).(a)	clinical epidemiology and biostatistics, <u>including</u>
859		<u>clinical study and experimental protocol design,</u>
860		<u>data collection, and analysis;</u>
861		
862	IV.A.5.b).(6).(a).(i)	clinical epidemiology and medical statistics;

863		and
864		
865	IV.A.5.b).(6).(a).(ii)	clinical study and experimental protocol
866		design, data collection, and analysis.
867		
868	IV.A.5.b).(6).(b)	the basic principles of laboratory and clinical
869		testing, quality control, quality assurance, and
870		proficiency standards;
871		
872	IV.A.5.b).(6).(c)	immune markers, immunophenotyping, flow
873		cytometry, cytochemical studies, and cytogenetic
874		and DNA analysis of neoplastic disorders;
875		
876	IV.A.5.b).(6).(d)	malignant and hematologic complications of organ
877		transplantation; and,
878		
879	IV.A.5.b).(6).(e)	<u>gene therapy.</u>
880		
881	IV.A.5.b).(7)	<u>must demonstrate knowledge of</u> principles of, indications
882		for, and limitations of:
883		
884	IV.A.5.b).(7).(a)	surgery in the treatment of cancer; and,
885		
886	IV.A.5.b).(7).(b)	principles of, indications for, and limitations of
887		radiation therapy in the treatment of cancer.
888		
889	IV.A.5.b).(8)	<u>must demonstrate knowledge of</u> principles of, indications
890		for, and complications of autologous and allogeneic bone
891		marrow or peripheral blood stem cell transplantation;
892		
893	IV.A.5.b).(9)	<u>must demonstrate knowledge of principles of, indications</u>
894		<u>for,</u> and complications of peripheral stem cell harvests;
895		
896	IV.A.5.b).(10)	<u>must demonstrate knowledge of the</u> management of post-
897		transplant complications;
898	IV.A.5.b).(11)	<u>must demonstrate knowledge of</u> All trainees should
899		understand the indications for, complications of, and risks
900		and limitations <u>associated with</u> to :
901		
902	IV.A.5.b).(11).(a)	thoracentesis;
903		
904	IV.A.5.b).(11).(b)	paracentesis;
905		
906	IV.A.5.b).(11).(c)	skin biopsies; and,
907		
908	IV.A.5.b).(11).(d)	lesion biopsies.
909		
910	IV.A.5.b).(12)	<u>must demonstrate knowledge of the use of</u>
911		chemotherapeutic drugs, biologic products, and growth
912		factors; their mechanisms of action, pharmacokinetics,
913		clinical indications <u>for,</u> and limitations <u>of chemotherapeutic</u>

914 drugs, biologic products, and growth factors, including their
915 effects, toxicity, and interactions.

916
917 **IV.A.5.c) Practice-based Learning and Improvement**

918
919 **Fellows must demonstrate the ability to investigate and**
920 **evaluate their care of patients, to appraise and assimilate**
921 **scientific evidence, and to continuously improve patient care**
922 **based on constant self-evaluation and life-long learning.**
923 **Fellows are expected to develop skills and habits to be able**
924 **to meet the following goals:**

925
926 **IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's**
927 **knowledge and expertise;**

928
929 **IV.A.5.c).(2) set learning and improvement goals;**

930
931 **IV.A.5.c).(3) identify and perform appropriate learning activities;**

932
933 **IV.A.5.c).(4) systematically analyze practice, using quality**
934 **improvement methods, and implement changes with**
935 **the goal of practice improvement;**

936
937 **IV.A.5.c).(5) incorporate formative evaluation feedback into daily**
938 **practice;**

939
940 **IV.A.5.c).(6) locate, appraise, and assimilate evidence from**
941 **scientific studies related to their patients' health**
942 **problems;**

943
944 **IV.A.5.c).(7) use information technology to optimize learning;**

945
946 **IV.A.5.c).(8) participate in the education of patients, families,**
947 **students, fellows and other health professionals; and,**

948
949 **IV.A.5.c).(9) *obtain procedure-specific informed consent by competently***
950 ***educating patients about rationale, technique, and***
951 ***complications of procedures.***

952
953 **IV.A.5.d) Interpersonal and Communication Skills**

954
955 **Fellows must demonstrate interpersonal and communication**
956 **skills that result in the effective exchange of information and**
957 **collaboration with patients, their families, and health**
958 **professionals. Fellows are expected to:**

959
960 **IV.A.5.d).(1) communicate effectively with patients, families, and**
961 **the public, as appropriate, across a broad range of**
962 **socioeconomic and cultural backgrounds;**

963

- 964 **IV.A.5.d).(2)** **communicate effectively with physicians, other health**
965 **professionals, and health related agencies;**
966
967 **IV.A.5.d).(3)** **work effectively as a member or leader of a health care**
968 **team or other professional group;**
969
970 **IV.A.5.d).(4)** **act in a consultative role to other physicians and**
971 **health professionals;**
972
973 **IV.A.5.d).(5)** **maintain comprehensive, timely, and legible medical**
974 **records, if applicable;**
975
976 **IV.A.5.d).(6)** demonstrate team leadership skills and the ability to work
977 with an interdisciplinary team by:
978
979 **IV.A.5.d).(6).(a)** identifying essential team members;
980
981 **IV.A.5.d).(6).(b)** defining the roles of team members; and,
982
983 **IV.A.5.d).(6).(c)** evaluating the role of the interdisciplinary team.
984
985 **IV.A.5.e)** **Professionalism**
986
987 **Fellows must demonstrate a commitment to carrying out**
988 **professional responsibilities and an adherence to ethical**
989 **principles. Fellows are expected to demonstrate:**
990
991 **IV.A.5.e).(1)** **compassion, integrity, and respect for others;**
992
993 **IV.A.5.e).(2)** **responsiveness to patient needs that supersedes self-**
994 **interest;**
995
996 **IV.A.5.e).(3)** **respect for patient privacy and autonomy;**
997
998 **IV.A.5.e).(4)** **accountability to patients, society and the profession;**
999
1000 **IV.A.5.e).(5)** **sensitivity and responsiveness to a diverse patient**
1001 **population, including but not limited to diversity in**
1002 **gender, age, culture, race, religion, disabilities, and**
1003 **sexual orientation;**
1004
1005 **IV.A.5.e).(6)** high standards of ethical behavior, including maintaining
1006 appropriate professional boundaries and relationships with
1007 other physicians and other health care team members, and
1008 avoiding conflicts of interest;
1009
1010 **IV.A.5.e).(7)** *a commitment to lifelong learning, and an attitude of caring*
1011 *that is derived from humanistic and professional values;*
1012 *and,*
1013

1014 IV.A.5.e).(8) personal development, attitudes, and coping skills of
1015 physicians and other health-care professionals who care
1016 for critically-ill patients.
1017

1018 **IV.A.5.f) Systems-based Practice**

1019
1020 **Fellows must demonstrate an awareness of and**
1021 **responsiveness to the larger context and system of health**
1022 **care, as well as the ability to call effectively on other**
1023 **resources in the system to provide optimal health care.**

1024 **Fellows are expected to:**

1025
1026 **IV.A.5.f).(1) work effectively in various health care delivery**
1027 **settings and systems relevant to their clinical**
1028 **specialty;**

1029
1030 **IV.A.5.f).(2) coordinate patient care within the health care system**
1031 **relevant to their clinical specialty;**

1032
1033 **IV.A.5.f).(3) incorporate considerations of cost awareness and**
1034 **risk-benefit analysis in patient and/or population-**
1035 **based care as appropriate;**

1036
1037 **IV.A.5.f).(4) advocate for quality patient care and optimal patient**
1038 **care systems;**

1039
1040 **IV.A.5.f).(5) work in interprofessional teams to enhance patient**
1041 **safety and improve patient care quality; and,**

1042
1043 **IV.A.5.f).(6) participate in identifying system errors and**
1044 **implementing potential systems solutions.**

1045
1046 IV.A.6. Curriculum Organization and Fellow Experiences

1047
1048 IV.A.6.a) A minimum of 12 months must be devoted to clinical experience.
1049

1050 IV.A.6.a).(1) At least 50% of the clinical experience must occur in the
1051 outpatient setting.

1052
1053 IV.A.6.a).(2) The program must provide at least one month of clinical
1054 experience in autologous and allogeneic bone marrow
1055 transplantation.

1056
1057 *IV.A.6.b) Fellows must participate in training using simulation.*

1058
1059 IV.A.6.c) Inpatient assignments should be of sufficient duration to permit
1060 continuing care of a majority of the patients throughout their
1061 hospitalization.

1062
1063 ~~The program~~ Fellows ~~must also~~ participate in a multidisciplinary

1064		case management or tumor <u>board</u> conferences and in protocol studies.
1065		
1066		
1067	IV.A.6.e)	Experience with Continuity Ambulatory Patients
1068		
1069		<i>Fellows must have continuity ambulatory clinic experience to</i>
1070		<i>develop a continuous healing relationship with patients for whom</i>
1071		<i>they provide medical oncology care. This continuity experience</i>
1072		<i>should expose <u>that exposes fellows them</u> to the breadth and depth</i>
1073		<i>of the subspecialty.</i>
1074		
1075	IV.A.6.e).(1)	Overall This experience should average one half-day each week.
1076		
1077		
1078	IV.A.6.e).(2)	Overall This experience must include an appropriate distribution of patients of <u>each both</u> gender and a diversity of ages, <u>which</u> . This should be accomplished <u>by through</u>
1079		<u>either</u> :
1080		
1081		
1082		
1083	IV.A.6.e).(2).(a)	a continuity clinic which provides fellows the opportunity to learn the course of disease; or,
1084		
1085		
1086	IV.A.6.e).(2).(b)	selected blocks of at least six months which address specific areas of oncologic disorders.
1087		
1088		
1089	IV.A.6.e).(3)	Each fellow should, on average, be responsible for four to eight patients during each half-day session.
1090		
1091		
1092	IV.A.6.e).(4)	The continuing patient care experience should not be interrupted by more than one month, excluding a fellow's vacation.
1093		
1094		
1095		
1096	IV.A.6.e).(5)	It is suggested that Fellows should be informed of the status of their continuity patients when <u>they such patients</u> are hospitalized, <u>as clinically appropriate</u> . so the fellows can make appropriate arrangements to maintain continuity of care.
1097		
1098		
1099		
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1101		
1102	IV.A.6.f)	<i>Procedures and Technical Skills</i>
1103		
1104	IV.A.6.f).(1)	<u>Direct faculty</u> supervision of procedures performed by each fellow must occur until proficiency has been acquired and documented by the program director.
1105		
1106		
1107		
1108	IV.A.6.f).(2)	A skilled preceptor <u>Faculty members</u> must be available to teach and supervise the fellows in the performance <u>and interpretation of these</u> procedures, Procedures which must be documented in each fellow's record, including indications, outcomes, diagnoses, and supervisor(s).
1109		
1110		
1111		
1112		
1113		
1114	IV.A.6.f).(3)	Fellows must acquire knowledge of and skill in education

1115		patients about the rationale, technique, and complications
1116		of procedures and in obtaining procedure-specific informed
1117		consent.
1118		
1119	IV.A.6.f).(4)	It is suggested that fellows have the opportunity to develop
1120		proficiency-competence in performing thoracentesis,
1121		paracentesis, and skin and lesion biopsies.
1122		
1123	IV.B.	Fellows' Scholarly Activities
1124		
1125	IV.B.1.	The curriculum must advance fellows' knowledge of the basic
1126		principles of research, including how research is conducted,
1127		evaluated, explained to patients, and applied to patient care.
1128		
1129	IV.B.2.	Fellows should participate in scholarly activity.
1130		
1131	IV.B.2.a)	<i>The majority of fellows must demonstrate evidence of recent</i>
1132		<i>research-productivity <u>scholarship conducted during the fellowship</u></i>
1133		<i>through <u>one or more of the following</u>:</i>
1134		
1135	IV.B.2.a).(1)	<i><u>publication of articles, book chapters, abstracts or case</u></i>
1136		<i><u>reports in peer-reviewed journals;</u></i>
1137		
1138	IV.B.2.a).(2)	<i><u>publication of peer-reviewed performance improvement or</u></i>
1139		<i><u>education research;</u></i>
1140		
1141	IV.B.2.a).(3)	<i><u>peer-reviewed funding; or,</u></i>
1142		
1143	IV.B.2.a).(4)	<i><u>peer-reviewed abstracts presented at <u>regional, state or</u></u></i>
1144		<i><u>national specialty meetings.</u></i>
1145		
1146	IV.B.3.	The sponsoring institution and program should allocate adequate
1147		educational resources to facilitate fellow involvement in scholarly
1148		activities.
1149		
1150	V.	Evaluation
1151		
1152	V.A.	Fellow
1153		
1154	V.A.1.	Formative Evaluation
1155		
1156	V.A.1.a)	The faculty must evaluate fellow performance in a timely
1157		manner during each rotation or similar educational
1158		assignment, and document this evaluation at completion of
1159		the assignment.
1160		
1161	V.A.1.a).(1)	<i>The faculty must discuss this evaluation with the <u>each</u></i>
1162		<i>fellow at the completion of the <u>each</u> assignment.</i>
1163		
1164	V.A.1.a).(2)	<i><u>Assessment of procedural competence should include a</u></i>

formal evaluation process and not be based solely on a minimum number of procedures performed.

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V.A.1.b)
V.A.1.b).(1)

The program must:

provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;

V.A.1.b).(1).(a)

Patient Care

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

V.A.1.b).(1).(a).(i)

Each program must define a standard criteria for proficiency competence for all required and elective procedures.

V.A.1.b).(1).(a).(ii)

The record of evaluation must include the fellow's logbook or an equivalent method to demonstrate that each fellow has achieved competence in the performance of required procedures.

V.A.1.b).(1).(b)

Medical Knowledge

The program must use an objective formative assessment method. The same formative assessment method must be administered at least twice during the program.

V.A.1.b).(1).(c)

Practice-based Learning and Improvement

The program must use practice performance data to assess the fellow in:

V.A.1.b).(1).(c).(i)

application of evidence to patient care;

V.A.1.b).(1).(c).(ii)

practice improvement;

V.A.1.b).(1).(c).(iii)

teaching skills involving peers and patients; and,

V.A.1.b).(1).(c).(iv)

scholarship.

V.A.1.b).(1).(d)

Interpersonal and Communication Skills

1216		
1217		
1218		<u>The program must use both direct observation and</u>
1219		<u>multi-source evaluation, including patients, peers</u>
1220		<u>and non-physician team members, to assess fellow</u>
1221		<u>performance in:</u>
1222	V.A. 1.b).(1).(d).(i)	<u>communication with patient and family;</u>
1223		
1224	V.A. 1.b).(1).(d).(ii)	<u>teamwork;</u>
1225		
1226	V.A. 1.b).(1).(d).(iii)	<u>communication with peers, including</u>
1227		<u>transitions in care; and,</u>
1228		
1229	V.A. 1.b).(1).(d).(iv)	<u>record keeping.</u>
1230		
1231	V.A. 1.b).(1).(e)	<u>Professionalism</u>
1232		
1233		<u>The program must use multi-source evaluation,</u>
1234		<u>including patients, peers, and non-physician team</u>
1235		<u>members, to assess each fellow's:</u>
1236		
1237	V.A. 1.b).(1).(e).(i)	<u>honesty and integrity;</u>
1238		
1239	V.A. 1.b).(1).(e).(ii)	<u>ability to meet professional responsibilities;</u>
1240		
1241	V.A. 1.b).(1).(e).(iii)	<u>ability to maintain appropriate professional</u>
1242		<u>relationships with patients and colleagues;</u>
1243		<u>and,</u>
1244		
1245	V.A. 1.b).(1).(e).(iv)	<u>commitment to self-improvement.</u>
1246		
1247	V.A. 1.b).(1).(f)	<u>Systems-based Practice</u>
1248		
1249		<u>The program must use multi-source evaluation,</u>
1250		<u>including peers, and non-physician team members,</u>
1251		<u>to assess each fellow's:</u>
1252		
1253	V.A. 1.b).(1).(f).(i)	<u>ability to provide care coordination,</u>
1254		<u>including transition of care;</u>
1255		
1256	V.A. 1.b).(1).(f).(ii)	<u>ability to work in interdisciplinary teams;</u>
1257		
1258	V.A. 1.b).(1).(f).(iii)	<u>advocacy for quality of care; and,</u>
1259		
1260	V.A. 1.b).(1).(f).(iv)	<u>ability to identify system problems and</u>
1261		<u>participate in improvement activities.</u>
1262		
1263	V.A.1.b).(2)	use multiple evaluators (e.g., faculty, peers, patients,
1264		self, and other professional staff);
1265		
1266	V.A.1.b).(3)	document progressive fellow performance

- 1267 improvement appropriate to educational level; and,
 1268
 1269 **V.A.1.b).(4)** provide each fellow with documented semiannual
 1270 evaluation of performance with feedback.
 1271
 1272 V.A.1.b).(4).(a) *Fellows' performance in continuity clinic must be*
 1273 *reviewed with them verbally and in writing at least*
 1274 *semiannually.*
 1275
 1276 **V.A.1.c)** The evaluations of fellow performance must be accessible for
 1277 review by the fellow, in accordance with institutional policy.
 1278
 1279 **V.A.2.** **Summative Evaluation**
 1280
 1281 The program director must provide a summative evaluation for each
 1282 fellow upon completion of the program. This evaluation must
 1283 become part of the fellow's permanent record maintained by the
 1284 institution, and must be accessible for review by the fellow in
 1285 accordance with institutional policy. This evaluation must:
 1286
 1287 **V.A.2.a)** document the fellow's performance during the final period of
 1288 education; and
 1289
 1290 **V.A.2.b)** verify that the fellow has demonstrated sufficient competence
 1291 to enter practice without direct supervision.
 1292
 1293 **V.B.** **Faculty Evaluation**
 1294
 1295 **V.B.1.** At least annually, the program must evaluate faculty performance as
 1296 it relates to the educational program.
 1297
 1298 **V.B.2.** These evaluations should include a review of faculty's clinical
 1299 teaching abilities, commitment to the educational program, clinical
 1300 knowledge, professionalism, and scholarly activities.
 1301
 1302 **V.B.3.** This evaluation must include at least annual written confidential
 1303 evaluations by fellows.
 1304
 1305 V.B.3.a) *~~In addition,~~ Fellows must have the opportunity to provide*
 1306 *confidential written evaluations of each supervising faculty*
 1307 *member at the end of a each rotation.*
 1308
 1309 V.B.3.b) *~~The program director must be reviewed~~ These evaluations must*
 1310 *be reviewed with each ~~attending~~ faculty member annually.*
 1311
 1312 **V.C.** **Program Evaluation and Improvement**
 1313
 1314 **V.C.1.** The program must document formal, systematic evaluation of the
 1315 curriculum at least annually. The program must monitor and track
 1316 each of the following areas:

1317		
1318	V.C.1.a)	fellow performance;
1319		
1320	V.C.1.b)	faculty development;
1321		
1322	V.C.1.c)	graduate performance, including performance of program graduates on the certification examination; and
1323		
1324		
1325	V.C.1.c).(1)	<i>At least 80% of <u>program's graduating fellows from those eligible to take an ABIM subspecialty certifying examination upon completion of their training for the most recently defined five year period who are eligible should must have taken an the ABIM subspecialty certifying examination.</u> (Note: Five-year rolling pass rate for first time takers of the ABIM certifying examination will be examined at each program review).</i>
1326		
1327		
1328		
1329		
1330		
1331		
1332		
1333		
1334	V.C.1.c).(2)	<i>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.</i>
1335		
1336		
1337		
1338	V.C.1.d)	program quality. Specifically:
1339		
1340	V.C.1.d).(1)	Fellows and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually.
1341		
1342		
1343		
1344	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.
1345		
1346		
1347		
1348	V.C.1.d).(3)	<i>At least 80% of the entering fellows should have completed the program when averaged over a five-year period.</i>
1349		
1350		
1351		
1352	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.
1353		
1354		
1355		
1356		
1357		
1358	V.C.3.	<i>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.</i>
1359		
1360		
1361		
1362	VI.	Fellow Duty Hours in the Learning and Working Environment
1363		
1364	VI.A.	Professionalism, Personal Responsibility, and Patient Safety
1365		
1366	VI.A.1.	Programs and sponsoring institutions must educate fellows and

- 1367 faculty members concerning the professional responsibilities of
 1368 physicians to appear for duty appropriately rested and fit to provide
 1369 the services required by their patients.
 1370
- 1371 **VI.A.2.** The program must be committed to and responsible for promoting
 1372 patient safety and fellow well-being in a supportive educational
 1373 environment.
 1374
- 1375 **VI.A.3.** The program director must ensure that fellows are integrated and
 1376 actively participate in interdisciplinary clinical quality improvement
 1377 and patient safety programs.
 1378
- 1379 **VI.A.4.** The learning objectives of the program must:
- 1380
- 1381 **VI.A.4.a)** be accomplished through an appropriate blend of supervised
 1382 patient care responsibilities, clinical teaching, and didactic
 1383 educational events; and,
 1384
- 1385 **VI.A.4.b)** not be compromised by excessive reliance on fellows to fulfill
 1386 non-physician service obligations.
 1387
- 1388 ~~VI.A.4.b).(1) ————— Fellows' service responsibilities must be limited to patients~~
 1389 ~~for whom the teaching service has diagnostic and~~
 1390 ~~therapeutic responsibility.~~
 1391
- 1392 **VI.A.5.** The program director and institution must ensure a culture of
 1393 professionalism that supports patient safety and personal
 1394 responsibility. Fellows and faculty members must demonstrate an
 1395 understanding and acceptance of their personal role in the
 1396 following:
 1397
- 1398 **VI.A.5.a)** assurance of the safety and welfare of patients entrusted to
 1399 their care;
 1400
- 1401 **VI.A.5.b)** provision of patient- and family-centered care;
 1402
- 1403 **VI.A.5.c)** assurance of their fitness for duty;
 1404
- 1405 **VI.A.5.d)** management of their time before, during, and after clinical
 1406 assignments;
 1407
- 1408 **VI.A.5.e)** recognition of impairment, including illness and fatigue, in
 1409 themselves and in their peers;
 1410
- 1411 **VI.A.5.f)** attention to lifelong learning;
 1412
- 1413 **VI.A.5.g)** the monitoring of their patient care performance improvement
 1414 indicators; and,
 1415
- 1416 **VI.A.5.h)** honest and accurate reporting of duty hours, patient

- 1417 outcomes, and clinical experience data.
1418
- 1419 **VI.A.6.** All fellows and faculty members must demonstrate responsiveness
1420 to patient needs that supersedes self-interest. Physicians must
1421 recognize that under certain circumstances, the best interests of the
1422 patient may be served by transitioning that patient's care to another
1423 qualified and rested provider.
1424
- 1425 **VI.B.** Transitions of Care
1426
- 1427 **VI.B.1.** Programs must design clinical assignments to minimize the number
1428 of transitions in patient care.
1429
- 1430 **VI.B.2.** Sponsoring institutions and programs must ensure and monitor
1431 effective, structured hand-over processes to facilitate both
1432 continuity of care and patient safety.
1433
- 1434 **VI.B.3.** Programs must ensure that fellows are competent in communicating
1435 with team members in the hand-over process.
1436
- 1437 **VI.B.4.** The sponsoring institution must ensure the availability of schedules
1438 that inform all members of the health care team of attending
1439 physicians and fellows currently responsible for each patient's care.
1440
- 1441 **VI.C.** Alertness Management/Fatigue Mitigation
1442
- 1443 **VI.C.1.** The program must:
1444
- 1445 **VI.C.1.a)** educate all faculty members and fellows to recognize the
1446 signs of fatigue and sleep deprivation;
1447
- 1448 **VI.C.1.b)** educate all faculty members and fellows in alertness
1449 management and fatigue mitigation processes; and,
1450
- 1451 **VI.C.1.c)** adopt fatigue mitigation processes to manage the potential
1452 negative effects of fatigue on patient care and learning, such
1453 as naps or back-up call schedules.
1454
- 1455 **VI.C.2.** Each program must have a process to ensure continuity of patient
1456 care in the event that a fellow may be unable to perform his/her
1457 patient care duties.
1458
- 1459 **VI.C.3.** The sponsoring institution must provide adequate sleep facilities
1460 and/or safe transportation options for fellows who may be too
1461 fatigued to safely return home.
1462
- 1463 **VI.D.** Supervision of Fellows
1464
- 1465 **VI.D.1.** In the clinical learning environment, each patient must have an
1466 identifiable, appropriately-credentialed and privileged attending

1467 physician (or licensed independent practitioner as approved by each
1468 Review Committee) who is ultimately responsible for that patient's
1469 care.
1470

1471 **VI.D.1.a)** This information should be available to fellows, faculty
1472 members, and patients.
1473

1474 **VI.D.1.b)** Fellows and faculty members should inform patients of their
1475 respective roles in each patient's care.
1476

1477 **VI.D.2.** The program must demonstrate that the appropriate level of
1478 supervision is in place for all fellows who care for patients.
1479

1480 Supervision may be exercised through a variety of methods. Some
1481 activities require the physical presence of the supervising faculty
1482 member. For many aspects of patient care, the supervising
1483 physician may be a more advanced resident or fellow. Other
1484 portions of care provided by the fellow can be adequately
1485 supervised by the immediate availability of the supervising faculty
1486 member or resident physician, either in the institution, or by means
1487 of telephonic and/or electronic modalities. In some circumstances,
1488 supervision may include post-hoc review of fellow-delivered care
1489 with feedback as to the appropriateness of that care.
1490

1491 **VI.D.3.** Levels of Supervision
1492

1493 To ensure oversight of fellow supervision and graded authority and
1494 responsibility, the program must use the following classification of
1495 supervision:
1496

1497 **VI.D.3.a)** Direct Supervision – the supervising physician is physically
1498 present with the fellow and patient.
1499

1500 **VI.D.3.b)** Indirect Supervision:
1501

1502 **VI.D.3.b).(1)** with direct supervision immediately available – the
1503 supervising physician is physically within the hospital
1504 or other site of patient care, and is immediately
1505 available to provide Direct Supervision.
1506

1507 **VI.D.3.b).(2)** with direct supervision available – the supervising
1508 physician is not physically present within the hospital
1509 or other site of patient care, but is immediately
1510 available by means of telephonic and/or electronic
1511 modalities, and is available to provide Direct
1512 Supervision.
1513

1514 **VI.D.3.c)** Oversight – the supervising physician is available to provide
1515 review of procedures/encounters with feedback provided
1516 after care is delivered.

- 1517
1518 **VI.D.4.** **The privilege of progressive authority and responsibility, conditional**
1519 **independence, and a supervisory role in patient care delegated to**
1520 **each fellow must be assigned by the program director and faculty**
1521 **members.**
1522
- 1523 **VI.D.4.a)** **The program director must evaluate each fellow’s abilities**
1524 **based on specific criteria. When available, evaluation should**
1525 **be guided by specific national standards-based criteria.**
1526
- 1527 **VI.D.4.b)** **Faculty members functioning as supervising physicians**
1528 **should delegate portions of care to fellows, based on the**
1529 **needs of the patient and the skills of the fellows.**
1530
- 1531 **VI.D.4.c)** **Senior residents or fellows should serve in a supervisory role**
1532 **of junior residents in recognition of their progress toward**
1533 **independence, based on the needs of each patient and the**
1534 **skills of the individual resident or fellow.**
1535
- 1536 **VI.D.5.** **Programs must set guidelines for circumstances and events in**
1537 **which fellows must communicate with appropriate supervising**
1538 **faculty members, such as the transfer of a patient to an intensive**
1539 **care unit, or end-of-life decisions.**
1540
- 1541 **VI.D.5.a)** **Each fellow must know the limits of his/her scope of**
1542 **authority, and the circumstances under which he/she is**
1543 **permitted to act with conditional independence.**
1544
- 1545 **VI.D.5.a).(1)** **In particular, PGY-1 residents should be supervised**
1546 **either directly or indirectly with direct supervision**
1547 **immediately available.**
1548
- 1549 **VI.D.6.** **Faculty supervision assignments should be of sufficient duration to**
1550 **assess the knowledge and skills of each fellow and delegate to**
1551 **him/her the appropriate level of patient care authority and**
1552 **responsibility.**
1553
- 1554 **VI.E.** **Clinical Responsibilities**
1555
- 1556 **The clinical responsibilities for each fellow must be based on PGY-level,**
1557 **patient safety, fellow education, severity and complexity of patient**
1558 **illness/condition and available support services.**
1559
- 1560 **VI.F.** **Teamwork**
1561
- 1562 **Fellows must care for patients in an environment that maximizes effective**
1563 **communication. This must include the opportunity to work as a member of**
1564 **effective interprofessional teams that are appropriate to the delivery of care**
1565 **in the specialty.**
1566

1567	VI.G.	Fellow Duty Hours
1568		
1569	VI.G.1.	Maximum Hours of Work per Week
1570		
1571		Duty hours must be limited to 80 hours per week, averaged over a
1572		four-week period, inclusive of all in-house call activities and all
1573		moonlighting.
1574		
1575	VI.G.1.a)	Duty Hour Exceptions
1576		
1577		A Review Committee may grant exceptions for up to 10% or a
1578		maximum of 88 hours to individual programs based on a
1579		sound educational rationale.
1580		
1581		<i>The Review Committee for Internal Medicine will not consider</i>
1582		<i>requests for exceptions to the 80-hour limit to the fellows' work</i>
1583		<i>week.</i>
1584		
1585	VI.G.1.a).(1)	In preparing a request for an exception the program
1586		director must follow the duty hour exception policy
1587		from the ACGME Manual on Policies and Procedures.
1588		
1589	VI.G.1.a).(2)	Prior to submitting the request to the Review
1590		Committee, the program director must obtain approval
1591		of the institution's GMEC and DIO.
1592		
1593	VI.G.2.	Moonlighting
1594		
1595	VI.G.2.a)	Moonlighting must not interfere with the ability of the fellow
1596		to achieve the goals and objectives of the educational
1597		program.
1598		
1599	VI.G.2.b)	Time spent by fellows in Internal and External Moonlighting
1600		(as defined in the ACGME Glossary of Terms) must be
1601		counted towards the 80-hour Maximum Weekly Hour Limit.
1602		
1603	VI.G.2.c)	PGY-1 residents are not permitted to moonlight.
1604		
1605	VI.G.3.	Mandatory Time Free of Duty
1606		
1607		Fellows must be scheduled for a minimum of one day free of duty
1608		every week (when averaged over four weeks). At-home call cannot
1609		be assigned on these free days.
1610		
1611	VI.G.4.	Maximum Duty Period Length
1612		
1613	VI.G.4.a)	Duty periods of PGY-1 residents must not exceed 16 hours in
1614		duration.
1615		
1616	VI.G.4.b)	Duty periods of PGY-2 residents and above may be

1617 scheduled to a maximum of 24 hours of continuous duty in
1618 the hospital. Programs must encourage fellows to use
1619 alertness management strategies in the context of patient
1620 care responsibilities. Strategic napping, especially after 16
1621 hours of continuous duty and between the hours of 10:00
1622 p.m. and 8:00 a.m., is strongly suggested.

1623

1624 **VI.G.4.b).(1)** It is essential for patient safety and fellow education
1625 that effective transitions in care occur. Fellows may be
1626 allowed to remain on-site in order to accomplish these
1627 tasks; however, this period of time must be no longer
1628 than an additional four hours.

1629

1630 **VI.G.4.b).(2)** Fellows must not be assigned additional clinical
1631 responsibilities after 24 hours of continuous in-house
1632 duty.

1633

1634 **VI.G.4.b).(3)** In unusual circumstances, fellows, on their own
1635 initiative, may remain beyond their scheduled period
1636 of duty to continue to provide care to a single patient.
1637 Justifications for such extensions of duty are limited
1638 to reasons of required continuity for a severely ill or
1639 unstable patient, academic importance of the events
1640 transpiring, or humanistic attention to the needs of a
1641 patient or family.

1642

1643 **VI.G.4.b).(3).(a)** Under those circumstances, the fellow must:

1644

1645 **VI.G.4.b).(3).(a).(i)** appropriately hand over the care of all
1646 other patients to the team responsible
1647 for their continuing care; and,

1648

1649 **VI.G.4.b).(3).(a).(ii)** document the reasons for remaining to
1650 care for the patient in question and
1651 submit that documentation in every
1652 circumstance to the program director.

1653

1654 **VI.G.4.b).(3).(b)** The program director must review each
1655 submission of additional service, and track
1656 both individual fellow and program-wide
1657 episodes of additional duty.

1658

1659 **VI.G.5. Minimum Time Off between Scheduled Duty Periods**

1660

1661 **VI.G.5.a)** PGY-1 residents should have 10 hours, and must have eight
1662 hours, free of duty between scheduled duty periods.

1663

1664 **VI.G.5.b)** Intermediate-level residents have 10 hours free of duty, and
1665 must have eight hours between scheduled duty periods. They
1666 must have at least 14 hours free of duty after 24 hours of in-

1667 house duty.

1668

1669 Internal medicine subspecialty fellows are considered to be in the

1670 final years of education.

1671

1672 **VI.G.5.c)** Residents in the final years of education be prepared to enter

1673 the unsupervised practice of medicine and care for patients

1674 over irregular or extended periods.

1675

1676 Internal medicine subspecialty fellows are considered to be in the

1677 final years of education.

1678

1679 **VI.G.5.c).(1)** This preparation must occur within the context of the

1680 80-hour, maximum duty period length, and one-day-

1681 off-in-seven standards. While it is desirable that

1682 fellows in their final years of education have eight

1683 hours free of duty between scheduled duty periods,

1684 there may be circumstances when these fellows must

1685 stay on duty to care for their patients or return to the

1686 hospital with fewer than eight hours free of duty.

1687

1688 **VI.G.5.c).(1).(a)** Circumstances of return-to-hospital activities

1689 with fewer than eight hours away from the

1690 hospital by fellows in their final years of

1691 education must be monitored by the program

1692 director.

1693

1694 **VI.G.5.c).(1).(b)** In unusual circumstances, fellows may remain

1695 beyond their scheduled period of duty or return

1696 after their scheduled period of duty to provide care

1697 to a single patient. Justifications for such

1698 extensions of duty are limited to reasons of

1699 required continuity of care for a severely ill or

1700 unstable patient, academic importance of the

1701 events transpiring, or humanistic attention to the

1702 needs of the patient or family. Such episodes

1703 should be rare, must be of the fellows' own

1704 initiative, and need not initiate a new 'off-duty

1705 period' nor require a change in the scheduled 'off-

1706 duty period.'

1707

1708 **VI.G.5.c).(1).(c)** Under such circumstances, the fellow must

1709 appropriately hand over care of all other patients to

1710 the team responsible for their continuing care, and

1711 document the reasons for remaining or returning to

1712 care for the patient in question and submit that

1713 documentation to the program director.

1714

1715 **VI.G.5.c).(1).(d)** The program director must review each submission

1716 of additional service and track both individual

1717 fellows' and program-wide episodes of additional

1718 duty.

1719

1720 **VI.G.6. Maximum Frequency of In-House Night Float**

1721

1722 **Fellows must not be scheduled for more than six consecutive nights**

1723 **of night float.**

1724

1725 **VI.G.7. Maximum In-House On-Call Frequency**

1726

1727 **PGY-2 residents and above must be scheduled for in-house call no**

1728 **more frequently than every-third-night (when averaged over a four-**

1729 **week period).**

1730

1731 *VI.G.7.a) ~~Internal Medicine residency programs are~~ fellowships must not*

1732 *~~allowed to average in-house call over a four-week period.~~*

1733

1734 **VI.G.8. At-Home Call**

1735

1736 **VI.G.8.a) Time spent in the hospital by fellows on at-home call must**

1737 **count towards the 80-hour maximum weekly hour limit. The**

1738 **frequency of at-home call is not subject to the every-third-**

1739 **night limitation, but must satisfy the requirement for one-day-**

1740 **in-seven free of duty, when averaged over four weeks.**

1741

1742 **VI.G.8.a).(1) At-home call must not be so frequent or taxing as to**

1743 **preclude rest or reasonable personal time for each**

1744 **fellow.**

1745

1746 **VI.G.8.b) Fellows are permitted to return to the hospital while on at-**

1747 **home call to care for new or established patients. Each**

1748 **episode of this type of care, while it must be included in the**

1749 **80-hour weekly maximum, will not initiate a new “off-duty**

1750 **period”.**

1751

1752 **VII. Innovative Projects**

1753

1754 **Requests for innovative projects that may deviate from the institutional, common**

1755 **and/or specialty specific program requirements must be approved in advance by**

1756 **the Review Committee. In preparing requests, the program director must follow**

1757 **Procedures for Approving Proposals for Innovative Projects located in the ACGME**

1758 **Manual on Policies and Procedures. Once a Review Committee approves a**

1759 **project, the sponsoring institution and program are jointly responsible for the**

1760 **quality of education offered to fellows for the duration of such a project.**

1761

1762 ***

1763

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