

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Rheumatology (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~~ Rheumatology 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 rheumatology must provide**
39 **~~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 rheumatology 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 rheumatology 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 each training program that do not~~
- 98 ~~number the number of accredited training per year in the program;~~
- 99
- 100 **I.B. Participating Sites**
- 101
- 102 **I.B.1. There must be a program letter of agreement (PLA) between the**

103 program and each participating site providing a required
104 assignment. The PLA must be renewed at least every five years.

105
106 The PLA should:

107
108 **I.B.1.a)** identify the faculty who will assume both educational and
109 supervisory responsibilities for fellows;

110
111 **I.B.1.b)** specify their responsibilities for teaching, supervision, and
112 formal evaluation of fellows, as specified later in this
113 document;

114
115 **I.B.1.c)** specify the duration and content of the educational
116 experience; and,

117
118 **I.B.1.d)** state the policies and procedures that will govern fellow
119 education during the assignment.

120
121 **I.B.2.** The program director must submit any additions or deletions of
122 participating sites routinely providing an educational experience,
123 required for all fellows, of one month full time equivalent (FTE) or
124 more through the Accreditation Council for Graduate Medical
125 Education (ACGME) Accreditation Data System (ADS).

126
127 **II. Program Personnel and Resources**

128
129 **II.A. Program Director**

130
131 **II.A.1.** There must be a single program director with authority and
132 accountability for the operation of the program. The sponsoring
133 institution's GMEC must approve a change in program director. After
134 approval, the program director must submit this change to the
135 ACGME via the ADS.

136
137 **II.A.2.** The program director should continue in his or her position for a
138 length of time adequate to maintain continuity of leadership and
139 program stability.

140
141 **II.A.3.** Qualifications of the program director must include:

142
143 **II.A.3.a)** requisite specialty expertise and documented educational
144 and administrative experience acceptable to the Review
145 Committee;

146
147 **II.A.3.a).(1)** The program director must have at least five years of
148 participation as an active faculty member in an ACGME-
149 accredited internal medicine residency or rheumatology
150 fellowship program.

151
152 **II.A.3.b)** current certification in the subspecialty by the American

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

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

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

304 fellows at that location.
305
306 The faculty must:
307
308 **II.B.1.a)** devote sufficient time to the educational program to fulfill
309 their supervisory and teaching responsibilities; and to
310 demonstrate a strong interest in the education of fellows;
311 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 one
357 ~~two~~ Key Clinical Faculty (KCF). KCF are attending physicians who
358 dedicate, on average, 10 hours per week throughout the year to the
359 ~~training program.~~ For programs with more than ~~four~~ three fellows, ~~enrolled~~
360 ~~during the accredited portion of the training program,~~ a ratio of KCF to
361 ~~fellows of at least 1:~~ there must be at least one KCF for every 1.5 fellows.
362 ~~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 rheumatology as a
368 discipline.
369
370 II.B.7.a).(2) KCF must have current ABIM certification in rheumatology.
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 ACGME competencies; and,*
391
392 *II.B.7.b).(3).(b) spend significant time in the evaluation of fellows,*
393 *including the direct observation of fellows with*
394 *patients.*
395
396 *II.B.7.b).(4) Appointment of one KCF to be an associate program*
397 *director is suggested.*
398
399 *II.B.8. ~~All~~ Clinical faculty members should participate in ~~prescribed~~ faculty*
400 *development programs designed to enhance the effectiveness of their*
401 *teaching.*
402
403 **II.C. Other Program Personnel**
404

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

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

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

416 **II.D. Resources**
417

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

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

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

428 II.D.2. *Facilities*
429

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

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

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

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

450 II.D.3. Laboratory and Imaging Services
451

452 ~~Each of~~ ~~†~~ ~~The following must be present at the primary training-~~
453 ~~clinical site or affiliated institution~~ participating site(s):
454

455 II.D.3.a).(1) access to clinical immunology lab services; and,

- 456
 457 II.D.3.a).(2) computerized tomography (CT), bone densitometry,
 458 magnetic resonance imaging (MRI), and angiography.
 459
 460 II.D.4. Other Facilities, Resources, or Support Services
 461
 462 II.D.4.a) Fellows must have access to a compensated polarized light
 463 microscope.
 464
 465 II.D.4.b) Fellows must have access to facilities for rehabilitation medicine.
 466
 467 II.D.4.c) There should be:
 468
 469 II.D.4.c).(1) orthopaedic surgery services for obtaining synovial
 470 biopsies and consultations for joint arthroplasty;
 471
 472 II.D.4.c).(2) other consultation services for obtaining indicated biopsies
 473 of muscle, nerve, skin, and arteries;
 474
 475 II.D.4.c).(3) access to pathology services for evaluation of muscle,
 476 vascular, and synovial biopsy materials; and,
 477
 478 II.D.4.c).(4) a meaningful working relationship, including availability for
 479 teaching and consultation, with a radiologist and
 480 orthopaedic surgeon.

481
 482 *II.D.5. Medical Records*

483
 484 Access to an electronic health record should be provided. In the absence
 485 of an existing electronic health record, institutions must demonstrate
 486 institutional commitment to its development and progress toward its
 487 implementation.
 488

489 II.D.6. Patient Population

490
 491 II.D.6.a) The patient population must have a variety of clinical problems
 492 and stages of diseases.
 493

494 II.D.6.b) *There must be patients of each ~~both sexes~~ gender, with a broad*
 495 *age range, including geriatric patients.*

496
 497 II.D.6.c) *A sufficient number of patients must be available to enable ~~ensure~~*
 498 *adequate inpatient and ambulatory experience for each fellow to*
 499 *achieve the required educational outcomes.*
 500

501 **II.E. Medical Information Access**

502
 503 **Fellows must have ready access to specialty-specific and other appropriate**
 504 **reference material in print or electronic format. Electronic medical literature**
 505 **databases with search capabilities should be available.**
 506

- 507 **III. Fellow Appointments**
508
- 509 **III.A. Eligibility Criteria**
510
- 511 **The program director must comply with the criteria for fellow eligibility as**
512 **specified in the Institutional Requirements.**
513
- 514 *III.A.1. ~~Prior to appointment in the fellowship program, fellows should have~~*
515 *~~completed an ACGME-accredited internal medicine education program.~~*
516
- 517 *III.A.2. ~~Fellows from non-ACGME-accredited internal medicine education~~*
518 *~~programs must have at least three years of internal medicine education~~*
519 *~~prior to starting the fellowship.~~*
520
- 521 *III.A.3. ~~The program director must inform non-ACGME trained applicants from~~*
522 *~~non-ACGME-accredited programs, prior to appointment, and in writing, of~~*
523 *~~the ABIM policies and procedures that may will affect the fellow's their~~*
524 *~~eligibility for ABIM certification.~~*
525
- 526 *III.A.4. ~~When averaged over any five-year period, a minimum of 75% of fellows in~~*
527 *~~each subspecialty training program must be graduates of an ACGME-~~*
528 *~~accredited internal medicine training program. Non-ACGME internal~~*
529 *~~medicine trained fellows must have at least three years of internal~~*
530 *~~medicine training prior to starting fellowship.~~*
531
- 532 **III.B. Number of Fellows**
533
- 534 **The program director may not appoint more fellows than approved by the**
535 **Review Committee, unless otherwise stated in the specialty-specific**
536 **requirements. The program's educational resources must be adequate to**
537 **support the number of fellows appointed to the program.**
538
- 539 *III.B.1. ~~The minimum number of available fellow positions in the training program~~*
540 *~~must be at least one per year not be less than the number of accredited~~*
541 *~~training years in the program.~~*
542
- 543 **III.C. Fellow Transfers**
544
- 545 **III.C.1. Before accepting a fellow who is transferring from another program,**
546 **the program director must obtain written or electronic verification of**
547 **previous educational experiences and a summative competency-**
548 **based performance evaluation of the transferring fellow.**
549
- 550 **III.C.2. A program director must provide timely verification of fellowship**
551 **education and summative performance evaluations for fellows who**
552 **leave the program prior to completion.**
553
- 554 **III.D. Appointment of Fellows and Other Learners**
555
- 556 **The presence of other learners (including, but not limited to, residents from**

557 other specialties, subspecialty fellows, PhD students, and nurse
558 practitioners) in the program must not interfere with the appointed fellows'
559 education. The program director must report the presence of other learners
560 to the DIO and GMEC in accordance with sponsoring institution guidelines.
561

562 **IV. Educational Program**

563
564 **IV.A. The curriculum must contain the following educational components:**

565
566 **IV.A.1. Overall educational goals for the program, which the program must**
567 **distribute to fellows and faculty annually;**

568
569 **IV.A.2. Competency-based goals and objectives for each assignment at**
570 **each educational level, which the program must distribute to fellows**
571 **and faculty annually, in either written or electronic form. These**
572 **should be reviewed by the fellow at the start of each rotation;**

573
574 **IV.A.3. Regularly scheduled didactic sessions;**

575
576 *IV.A.3.a) The core curriculum must include a didactic program based upon*
577 *the core knowledge content in the subspecialty area.*

578
579 *IV.A.3.a).(1) The program must afford each fellow an opportunity to*
580 *review topics covered in conferences that he or she was*
581 *unable to attend.*

582
583 *IV.A.3.a).(2) Fellows must participate in clinical case conferences,*
584 *journal clubs, research conference, and morbidity and*
585 *mortality or quality improvement conferences.*

586
587 *IV.A.3.a).(3) All core conferences must have at least one faculty*
588 *member present, and must be scheduled as to ensure*
589 *peer-peer and peer-faculty interaction.*

590
591 *IV.A.3.b) Patient-based teaching must include direct interaction between*
592 *fellows and ~~attending~~ faculty members, bedside teaching,*
593 *discussion of pathophysiology, and the use of current evidence in*
594 *diagnostic and therapeutic decisions. The teaching must be:*

595
596 | *IV.A.3.b).(1) formally conducted on all inpatient, outpatient, and*
597 *consultative services; and,*

598
599 *IV.A.3.b).(2) conducted with a frequency and duration sufficient to that*
600 *ensures a meaningful and continuous teaching relationship*
601 *between the assigned supervising faculty member(s)*
602 *teaching attending and fellows.*

603
604 *IV.A.3.c) Fellows must receive instruction in practice management relevant*
605 *to rheumatology.*

606
607 **IV.A.4. Delineation of fellow responsibilities for patient care, progressive**

608 responsibility for patient management, and supervision of fellows
609 over the continuum of the program.

610
611 **IV.A.5. ACGME Competencies**

612
613 **The program must integrate the following ACGME competencies**
614 **into the curriculum:**

615
616 **IV.A.5.a) Patient Care**

617
618 **Fellows must be able to provide patient care that is**
619 **compassionate, appropriate, and effective for the treatment of**
620 **health problems and the promotion of health. Fellows:**

621
622 *IV.A.5.a).(1) must demonstrate competence in the practice of health*
623 *promotion, disease prevention, diagnosis, care, and*
624 *treatment of ~~men and women~~ patients of each gender,*
625 *from adolescence to old age, during health and all stages*
626 *of illness;*

627
628 *IV.A.5.a).(2) must demonstrate competence in treating are expected to*
629 *learn the practice of health promotion, disease prevention,*
630 *diagnosis, care, and treatment of men and women from*
631 *adolescence to old age, during health and all stages of*
632 *illness as it relates to the following disorders:*

633
634 *IV.A.5.a).(2).(a) crystal induced synovitis;*

635
636 *IV.A.5.a).(2).(b) infection of joints and soft tissues;*

637
638 *IV.A.5.a).(2).(c) metabolic diseases of bone;*

639
640 *IV.A.5.a).(2).(d) nonarticular rheumatic diseases, including*
641 *fibromyalgia;*

642
643 *IV.A.5.a).(2).(e) pediatric rheumatic diseases, ~~where~~ it is suggested*
644 *that programs with the qualified faculty members*
645 *and facilities provide training;*

646
647 *IV.A.5.a).(2).(f) nonsurgical, exercise-related (sports) injury;*

648
649 *IV.A.5.a).(2).(g) polymyositis;*

650
651 *IV.A.5.a).(2).(h) osteoarthritis;*

652
653 *IV.A.5.a).(2).(i) osteoporosis;*

654
655 *IV.A.5.a).(2).(j) regional musculoskeletal pain syndromes, ~~and~~*
656 *acute and chronic musculoskeletal pain*
657 *syndromes, and exercise-related syndromes;*
658

- 659 IV.A.5.a).(2).(k) rheumatoid arthritis;
660
661 IV.A.5.a).(2).(l) scleroderma/systemic sclerosis;
662
663 IV.A.5.a).(2).(m) Sjögren's Syndrome;
664
665 IV.A.5.a).(2).(n) spondyloarthropathies;
666
667 IV.A.5.a).(2).(o) systemic diseases with rheumatic manifestations;
668
669 IV.A.5.a).(2).(p) systemic lupus erythematosus; and,
670
671 IV.A.5.a).(2).(q) vasculitis.
672
673 IV.A.5.a).(3) ~~are expected to~~ must demonstrate competence in:
674
675 IV.A.5.a).(3).(a) the examination and interpretation of synovial fluid
676 under conventional and polarized light microscopy;
677
678 IV.A.5.a).(3).(b) the interpretation of radiographs of normal and
679 diseased joints, bones, periarticular structures, and
680 prosthetic joints;
681
682 IV.A.5.a).(3).(c) musculoskeletal pain assessment and pain-
683 management; and,
684
685 IV.A.5.a).(3).(d) performing arthrocentesis of peripheral joints and
686 periarticular/soft tissue injections.
687

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:

- 695 IV.A.5.b).(1) ~~must demonstrate knowledge of the scientific method of~~
696 ~~problem solving and evidence-based decision making.-~~
697 ~~commitment to lifelong learning, and an attitude of caring~~
698 ~~that is derived from humanistic and professional values.~~
699
700 IV.A.5.b).(2) ~~must develop~~ demonstrate knowledge understanding of
701 indications, contraindications, limitations, complications,
702 techniques, and interpretation of results of those diagnostic
703 and therapeutic procedures integral to the discipline,
704 including the appropriate indications for and use of
705 screening tests/procedures.
706
707 IV.A.5.b).(2).(a) This must include knowledge of the indications for
708 and the interpretation of:
709

710	IV.A.5.b).(2).(a).(i)	<u>arthroscopy;</u>
711		
712	IV.A.5.b).(2).(a).(ii)	biopsy specimens, including histochemistry and immunofluorescence of tissues relevant to the diagnosis of rheumatic diseases;
713		
714		
715		
716	IV.A.5.b).(2).(a).(iii)	bone densitometry;
717		
718	IV.A.5.b).(2).(a).(iv)	computed tomography <u>CT</u> of lungs and paranasal sinuses <u>for patients with suspected or confirmed rheumatic disorders;</u>
719		
720		
721		
722		
723	IV.A.5.b).(2).(a).(v)	electromyograms and nerve conduction studies <u>for patients with suspected or confirmed rheumatic disorders;</u>
724		
725		
726		
727	IV.A.5.b).(2).(a).(vi)	magnetic resonance imaging <u>MRI</u> of the central nervous system (brain and spinal cord) <u>for patients with suspected or confirmed rheumatic disorders;</u>
728		
729		
730		
731		
732	IV.A.5.b).(2).(a).(vii)	<u>plain radiography, arthrography, ultrasonography, radionuclide scans, computed tomography</u> CT, magnetic resonance imaging and MRI of joints, bones and periarticular structures;
733		
734		
735		
736		
737		
738	IV.A.5.b).(2).(a).(viii)	radionuclide scans of bones and joints; arteriograms (conventional and MRI/MRA) for patients with suspected or confirmed vasculitis;
739		
740		
741		
742		
743	IV.A.5.b).(2).(a).(ix)	Schirmer's and rose Bengal tests; and,
744		
745	IV.A.5.b).(2).(a).(x)	parotid scans and salivary flow studies.
746		
747	IV.A.5.b).(3)	<u>must demonstrate knowledge of:</u>
748		
749	IV.A.5.b).(3).(a)	the anatomy, basic immunology, genetic basis, cell biology and metabolism pertaining to rheumatic diseases, disorders of connective tissue, metabolic disease of bone, osteoporosis, and musculoskeletal pain syndromes;
750		
751		
752		
753		
754		
755	IV.A.5.b).(3).(b)	the pathogenesis, epidemiology, clinical expression, treatments, and prognosis of the full range of rheumatic and musculoskeletal diseases;
756		
757		
758		
759	IV.A.5.b).(3).(c)	the physical and biologic basis of the range of diagnostic testing in rheumatology, and the clinical
760		

- 761 test characteristics of these procedures;
 762
 763 IV.A.5.b).(3).(d) the pharmacokinetics, metabolism, adverse events,
 764 interactions, and relative costs of drug therapies
 765 used in the management of rheumatic disorders;
 766
 767 IV.A.5.b).(3).(e) the aging influences on musculoskeletal function
 768 and responses to prescribed therapies for
 769 rheumatic diseases; and,
 770
 771 IV.A.5.b).(3).(f) the essential components of quality experimental
 772 design, clinical trial design, data analysis, and
 773 interpretation of results, and the importance of
 774 adherence to ethical standards of experimentation.
 775
 776 IV.A.5.b).(4) must demonstrate knowledge of the appropriate
 777 employment of principles of physical medicine and
 778 rehabilitation in the care of patients with rheumatic
 779 disorders; and,
 780
 781 IV.A.5.b).(5) must demonstrate a knowledge of the indications for
 782 surgical and orthopaedic consultation, including indications
 783 for arthroscopy and joint replacement/arthroplasty.
 784

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:

- 794 **IV.A.5.c).(1)** identify strengths, deficiencies, and limits in one's
 795 knowledge and expertise;
 796
 797 **IV.A.5.c).(2)** set learning and improvement goals;
 798
 799 **IV.A.5.c).(3)** identify and perform appropriate learning activities;
 800
 801 **IV.A.5.c).(4)** systematically analyze practice, using quality
 802 improvement methods, and implement changes with
 803 the goal of practice improvement;
 804
 805 **IV.A.5.c).(5)** incorporate formative evaluation feedback into daily
 806 practice;
 807
 808 **IV.A.5.c).(6)** locate, appraise, and assimilate evidence from
 809 scientific studies related to their patients' health
 810 problems;

811		
812	IV.A.5.c).(7)	use information technology to optimize learning; and,
813		
814	IV.A.5.c).(8)	participate in the education of patients, families,
815		students, fellows and other health professionals.
816		
817	IV.A.5.d)	Interpersonal and Communication Skills
818		
819		Fellows must demonstrate interpersonal and communication
820		skills that result in the effective exchange of information and
821		collaboration with patients, their families, and health
822		professionals. Fellows are expected to:
823		
824	IV.A.5.d).(1)	communicate effectively with patients, families, and
825		the public, as appropriate, across a broad range of
826		socioeconomic and cultural backgrounds;
827		
828	IV.A.5.d).(2)	communicate effectively with physicians, other health
829		professionals, and health related agencies;
830		
831	IV.A.5.d).(3)	work effectively as a member or leader of a health care
832		team or other professional group;
833		
834	IV.A.5.d).(4)	act in a consultative role to other physicians and
835		health professionals; and,
836		
837	IV.A.5.d).(5)	maintain comprehensive, timely, and legible medical
838		records, if applicable.
839		
840	IV.A.5.e)	Professionalism
841		
842		Fellows must demonstrate a commitment to carrying out
843		professional responsibilities and an adherence to ethical
844		principles. Fellows are expected to demonstrate:
845		
846	IV.A.5.e).(1)	compassion, integrity, and respect for others;
847		
848	IV.A.5.e).(2)	responsiveness to patient needs that supersedes self-
849		interest;
850		
851	IV.A.5.e).(3)	respect for patient privacy and autonomy;
852		
853	IV.A.5.e).(4)	accountability to patients, society and the profession;
854		
855	IV.A.5.e).(5)	sensitivity and responsiveness to a diverse patient
856		population, including but not limited to diversity in
857		gender, age, culture, race, religion, disabilities, and
858		sexual orientation;
859		
860	IV.A.5.e).(6)	<u>high standards of ethical behavior, including maintaining</u>

861 appropriate professional boundaries and relationships with
862 other physicians and other health care team members, and
863 avoiding conflicts of interest; and,

864
865 IV.A.5.e).(7) a commitment to lifelong learning, and an attitude of caring
866 derived from humanistic and professional values.
867

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

869
870 **Fellows must demonstrate an awareness of and**
871 **responsiveness to the larger context and system of health**
872 **care, as well as the ability to call effectively on other**
873 **resources in the system to provide optimal health care.**
874 **Fellows are expected to:**

875
876 **IV.A.5.f).(1) work effectively in various health care delivery**
877 **settings and systems relevant to their clinical**
878 **specialty;**

879
880 **IV.A.5.f).(2) coordinate patient care within the health care system**
881 **relevant to their clinical specialty;**

882
883 **IV.A.5.f).(3) incorporate considerations of cost awareness and**
884 **risk-benefit analysis in patient and/or population-**
885 **based care as appropriate;**

886
887 **IV.A.5.f).(4) advocate for quality patient care and optimal patient**
888 **care systems;**

889
890 **IV.A.5.f).(5) work in interprofessional teams to enhance patient**
891 **safety and improve patient care quality; and,**

892
893 **IV.A.5.f).(6) participate in identifying system errors and**
894 **implementing potential systems solutions.**

895
896 **IV.A.6. Curriculum Organization and Fellows Experiences**

897
898 **IV.A.6.a) A minimum of 12 months must be devoted to clinical experience.**

899
900 **IV.A.6.b) Fellows must participate in training using simulation.**

901
902 **IV.A.6.c) Experience with Continuity Ambulatory Patients**

903
904 ~~Fellows must have continuity ambulatory clinic experience to~~
905 ~~develop a continuous healing relationship with patients for whom~~
906 ~~they provide rheumatologic care. This continuity experience~~
907 ~~should that exposes fellows them to the breadth and depth of~~
908 ~~rheumatology.~~

909
910 **IV.A.6.c).(1) Overall-This experience should average one half-day each**

- 911 week.
- 912
- 913 IV.A.6.c).(2) The program must include a minimum of two half-days of
914 ambulatory care per week, averaged over the two years of
915 ~~training education~~, which includes the continuity
916 ambulatory experience.
- 917
- 918 IV.A.6.c).(3) Three half-days per week of ambulatory care are
919 suggested.
- 920
- 921 IV.A.6.c).(4) ~~Overall~~ This experience must include an appropriate
922 distribution of patients of each ~~both~~ gender and a diversity
923 of ages, and. ~~This should be accomplished by through~~
924 either:
- 925
- 926 IV.A.6.c).(4).(a) a continuity clinic which provides fellows the
927 opportunity to learn the course of disease; or,
928
- 929 IV.A.6.c).(4).(b) selected blocks of at least six months which
930 address specific areas of rheumatologic diseases.
- 931
- 932 IV.A.6.c).(5) Each fellow should, on average, be responsible for four to
933 eight patients during each half-day session.
- 934
- 935 IV.A.6.c).(6) The continuing patient care experience should not be
936 interrupted by more than one month, excluding a fellow's
937 vacation.
- 938
- 939 IV.A.6.c).(7) Continuity patients should not be limited to one disease
940 type, but should expose fellows to patients with a broad
941 variety and stage of disease.
- 942
- 943 IV.A.6.c).(8) ~~It is suggested that~~ Fellows should be informed of the
944 status of their continuity patients when they such patients
945 are hospitalized, as clinically appropriate. ~~so the fellows~~
946 ~~can make appropriate arrangements to maintain continuity~~
947 ~~of care.~~
- 948
- 949 IV.A.6.d) Procedures and Technical Skills
- 950
- 951 IV.A.6.d).(1) *Direct faculty supervision of procedures performed by each
952 fellow must occur until proficiency has been acquired and
953 documented by the program director.*
- 954
- 955 IV.A.6.d).(2) ~~A skilled preceptor~~ Faculty must be available to teach and
956 supervise the fellows in the performance and interpretation
957 ~~of these procedures.~~ Procedures which must be
958 documented in each fellow's record, including indications,
959 outcomes, diagnoses, and supervisor(s).
- 960
- 961 IV.A.6.e) ~~The~~ Fellows must have experience ~~be given opportunities to~~

962 function in the role of a rheumatology consultant in both the
963 inpatient and outpatient settings.

964
965 **IV.B. Fellows' Scholarly Activities**

966
967 **IV.B.1. The curriculum must advance fellows' knowledge of the basic**
968 **principles of research, including how research is conducted,**
969 **evaluated, explained to patients, and applied to patient care.**

970
971 **IV.B.2. Fellows should participate in scholarly activity.**

972
973 *IV.B.2.a) The majority of fellows must demonstrate evidence of ~~recent~~*
974 *~~research productivity~~ scholarship conducted during the fellowship*
975 *through one or more of the following:*

976
977 *IV.B.2.a).(1) publication of articles, book chapters, abstract, or case*
978 *reports in peer-reviewed journals;*

979
980 *IV.B.2.a).(2) publication of peer-reviewed performance improvement or*
981 *education research;*

982
983 *IV.B.2.a).(3) peer-reviewed funding; or,*

984
985 *IV.B.2.a).(4) peer-reviewed abstracts presented at regional, state, or*
986 *national specialty meetings.*

987
988 **IV.B.3. The sponsoring institution and program should allocate adequate**
989 **educational resources to facilitate fellow involvement in scholarly**
990 **activities.**

991
992 **V. Evaluation**

993
994 **V.A. Fellow**

995
996 **V.A.1. Formative Evaluation**

997
998 **V.A.1.a) The faculty must evaluate fellow performance in a timely**
999 **manner during each rotation or similar educational**
1000 **assignment, and document this evaluation at completion of**
1001 **the assignment.**

1002
1003 *V.A.1.a).(1) The faculty must discuss this evaluation with ~~the~~ each*
1004 *fellow at the completion of ~~the~~ each assignment.*

1005
1006 *V.A.1.a).(2) Assessment of procedural competence should include a*
1007 *formal evaluation process and not be based solely on a*
1008 *minimum number of procedures performed.*

1009
1010 **V.A.1.b) The program must:**

1011

1012	V.A.1.b).(1)	provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;
1013		
1014		
1015		
1016		
1017		
1018	V.A.1.b).(1).(a)	<u>Patient Care</u>
1019		
1020		<u>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.</u>
1021		
1022		
1023		
1024		
1025		
1026	V.A.1.b).(1).(a).(i)	<u>Each program must define a standard criteria for proficiency competence for all required and elective procedures.</u>
1027		
1028		
1029		
1030	V.A.1.b).(1).(a).(ii)	<u>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.</u>
1031		
1032		
1033		
1034		
1035		
1036	V.A.1.b).(1).(b)	<u>Medical Knowledge</u>
1037		
1038		<u>The program must use an objective formative assessment method. The same formative assessment method must be administered at least twice during the program.</u>
1039		
1040		
1041		
1042		
1043	V.A.1.b).(1).(c)	<u>Practice-based Learning and Improvement</u>
1044		
1045		<u>The program must use performance data to assess fellow in:</u>
1046		
1047		
1048	V.A.1.b).(1).(c).(i)	<u>application of evidence to patient care;</u>
1049		
1050	V.A.1.b).(1).(c).(ii)	<u>practice improvement;</u>
1051		
1052	V.A.1.b).(1).(c).(iii)	<u>teaching skills involving peers and patients;</u>
1053		<u>and,</u>
1054		
1055	V.A.1.b).(1).(c).(iv)	<u>scholarship.</u>
1056		
1057	V.A.1.b).(1).(d)	<u>Interpersonal and Communication Skills</u>
1058		
1059		<u>The program must use both direct observation and multi-source evaluation, including patients, peers and non-physician team members, to assess fellow performance in:</u>
1060		
1061		
1062		

1063		
1064	V.A. 1.b).(1).(d).(i)	<u>communication with patient and family;</u>
1065		
1066	V.A. 1.b).(1).(d).(ii)	<u>teamwork;</u>
1067		
1068	V.A. 1.b).(1).(d).(iii)	<u>communication with peers, including</u>
1069		<u>transitions in care; and,</u>
1070		
1071	V.A. 1.b).(1).(d).(iv)	<u>record keeping.</u>
1072		
1073	V.A. 1.b).(1).(e)	<u>Professionalism</u>
1074		
1075		<u>The program must use multi-source evaluation,</u>
1076		<u>including patients, peers, and non-physician team</u>
1077		<u>members, to assess each fellow's:</u>
1078		
1079	V.A. 1.b).(1).(e).(i)	<u>honesty and integrity;</u>
1080		
1081	V.A. 1.b).(1).(e).(ii)	<u>ability to meet professional responsibilities;</u>
1082		
1083	V.A. 1.b).(1).(e).(iii)	<u>ability to maintain appropriate professional</u>
1084		<u>relationships with patients and colleagues;</u>
1085		<u>and,</u>
1086		
1087	V.A. 1.b).(1).(e).(iv)	<u>commitment to self-improvement.</u>
1088		
1089	V.A. 1.b).(1).(f)	<u>Systems-based Practice</u>
1090		
1091		<u>The program must use multi-source evaluation,</u>
1092		<u>including peers, and non-physician team members,</u>
1093		<u>to assess each fellow's:</u>
1094		
1095	V.A. 1.b).(1).(f).(i)	<u>ability to provide care coordination,</u>
1096		<u>including transition of care;</u>
1097		
1098	V.A. 1.b).(1).(f).(ii)	<u>ability to work in interdisciplinary teams;</u>
1099		
1100	V.A. 1.b).(1).(f).(iii)	<u>advocacy for quality of care; and,</u>
1101		
1102	V.A. 1.b).(1).(f).(iv)	<u>ability to identify system problems and</u>
1103		<u>participate in improvement activities.</u>
1104		
1105	V.A.1.b).(2)	use multiple evaluators (e.g., faculty, peers, patients,
1106		self, and other professional staff);
1107		
1108	V.A.1.b).(3)	document progressive fellow performance
1109		improvement appropriate to educational level; and,
1110		
1111	V.A.1.b).(4)	provide each fellow with documented semiannual
1112		evaluation of performance with feedback.
1113		

- 1114 V.A.1.b).(4).(a) *Fellows' performance in continuity clinic must be*
 1115 *reviewed with them verbally and in writing at least*
 1116 *semiannually.*
 1117
- 1118 **V.A.1.c)** **The evaluations of fellow performance must be accessible for**
 1119 **review by the fellow, in accordance with institutional policy.**
 1120
- 1121 **V.A.2.** **Summative Evaluation**
 1122
 1123 **The program director must provide a summative evaluation for each**
 1124 **fellow upon completion of the program. This evaluation must**
 1125 **become part of the fellow's permanent record maintained by the**
 1126 **institution, and must be accessible for review by the fellow in**
 1127 **accordance with institutional policy. This evaluation must:**
 1128
- 1129 **V.A.2.a)** **document the fellow's performance during the final period of**
 1130 **education; and,**
 1131
- 1132 **V.A.2.b)** **verify that the fellow has demonstrated sufficient competence**
 1133 **to enter practice without direct supervision.**
 1134
- 1135 **V.B.** **Faculty Evaluation**
 1136
- 1137 **V.B.1.** **At least annually, the program must evaluate faculty performance as**
 1138 **it relates to the educational program.**
 1139
- 1140 **V.B.2.** **These evaluations should include a review of faculty's clinical**
 1141 **teaching abilities, commitment to the educational program, clinical**
 1142 **knowledge, professionalism, and scholarly activities.**
 1143
- 1144 **V.B.3.** **This evaluation must include at least annual written confidential**
 1145 **evaluations by fellows.**
 1146
- 1147 *V.B.3.a)* *~~In addition,~~ Fellows must have the opportunity to provide*
 1148 *confidential written evaluations of each supervising faculty*
 1149 *member at the end of a each rotation.*
 1150
- 1151 *V.B.3.b)* *~~The program director must be reviewed~~ These evaluations must*
 1152 *be reviewed with each attending faculty member annually.*
 1153
- 1154 **V.C.** **Program Evaluation and Improvement**
 1155
- 1156 **V.C.1.** **The program must document formal, systematic evaluation of the**
 1157 **curriculum at least annually. The program must monitor and track**
 1158 **each of the following areas:**
 1159
- 1160 **V.C.1.a)** **fellow performance;**
 1161
- 1162 **V.C.1.b)** **faculty development;**
 1163

- 1164 **V.C.1.c)** graduate performance, including performance of program
 1165 graduates on the certification examination; and,
 1166
- 1167 **V.C.1.c).(1)** *At least 80% of ~~program's~~ graduating fellows from those
 1168 eligible to take an ABIM subspecialty certifying
 1169 examination upon completion of their training for the most
 1170 recently defined five year period who are eligible should
 1171 must have taken an the ABIM subspecialty certifying
 1172 examination. (Note: Five-year rolling pass rate for first time
 1173 takers of the ABIM certifying examination will be examined
 1174 at each program review).*
- 1175
- 1176 **V.C.1.c).(2)** *At least 80% of a program's graduates taking the ABIM
 1177 certifying examination for the first time during the most
 1178 recently defined five year period should pass.*
- 1179
- 1180 **V.C.1.d)** program quality. Specifically:
 1181
- 1182 **V.C.1.d).(1)** **Fellows and faculty must have the opportunity to**
 1183 **evaluate the program confidentially and in writing at**
 1184 **least annually.**
- 1185
- 1186 **V.C.1.d).(2)** **The program must use the results of fellows'**
 1187 **assessments of the program together with other**
 1188 **program evaluation results to improve the program.**
- 1189
- 1190 **V.C.1.d).(3)** *At least 80% of the entering fellows should have
 1191 completed the program when averaged over a five-year
 1192 period.*
- 1193
- 1194 **V.C.2.** **If deficiencies are found, the program should prepare a written plan**
 1195 **of action to document initiatives to improve performance in the**
 1196 **areas listed in section V.C.1. The action plan should be reviewed**
 1197 **and approved by the teaching faculty and documented in meeting**
 1198 **minutes.**
- 1199
- 1200 **V.C.3.** *Representative program personnel, at a minimum to include the program
 1201 director, representative faculty, and one fellow, must review program
 1202 goals and objectives, and the effectiveness with which they are achieved.*
- 1203
- 1204 **VI. Fellow Duty Hours in the Learning and Working Environment**
- 1205
- 1206 **VI.A. Professionalism, Personal Responsibility, and Patient Safety**
- 1207
- 1208 **VI.A.1. Programs and sponsoring institutions must educate fellows and**
 1209 **faculty members concerning the professional responsibilities of**
 1210 **physicians to appear for duty appropriately rested and fit to provide**
 1211 **the services required by their patients.**
- 1212
- 1213 **VI.A.2. The program must be committed to and responsible for promoting**

1214		patient safety and fellow well-being in a supportive educational
1215		environment.
1216		
1217	VI.A.3.	The program director must ensure that fellows are integrated and
1218		actively participate in interdisciplinary clinical quality improvement
1219		and patient safety programs.
1220		
1221	VI.A.4.	The learning objectives of the program must:
1222		
1223	VI.A.4.a)	be accomplished through an appropriate blend of supervised
1224		patient care responsibilities, clinical teaching, and didactic
1225		educational events; and,
1226		
1227	VI.A.4.b)	not be compromised by excessive reliance on fellows to fulfill
1228		non-physician service obligations.
1229		
1230	<i>VI.A.4.b).(1)</i>	<i>Fellows' service responsibilities must be limited to patients</i>
1231		<i>for whom the teaching service has diagnostic and</i>
1232		<i>therapeutic responsibility.</i>
1233		
1234	VI.A.5.	The program director and institution must ensure a culture of
1235		professionalism that supports patient safety and personal
1236		responsibility. Fellows and faculty members must demonstrate an
1237		understanding and acceptance of their personal role in the
1238		following:
1239		
1240	VI.A.5.a)	assurance of the safety and welfare of patients entrusted to
1241		their care;
1242		
1243	VI.A.5.b)	provision of patient- and family-centered care;
1244		
1245	VI.A.5.c)	assurance of their fitness for duty;
1246		
1247	VI.A.5.d)	management of their time before, during, and after clinical
1248		assignments;
1249		
1250	VI.A.5.e)	recognition of impairment, including illness and fatigue, in
1251		themselves and in their peers;
1252		
1253	VI.A.5.f)	attention to lifelong learning;
1254		
1255	VI.A.5.g)	the monitoring of their patient care performance improvement
1256		indicators; and,
1257		
1258	VI.A.5.h)	honest and accurate reporting of duty hours, patient
1259		outcomes, and clinical experience data.
1260		
1261	VI.A.6.	All fellows and faculty members must demonstrate responsiveness
1262		to patient needs that supersedes self-interest. Physicians must
1263		recognize that under certain circumstances, the best interests of the

1264 patient may be served by transitioning that patient's care to another
1265 qualified and rested provider.

1266
1267 **VI.B. Transitions of Care**

1268
1269 **VI.B.1. Programs must design clinical assignments to minimize the number**
1270 **of transitions in patient care.**

1271
1272 **VI.B.2. Sponsoring institutions and programs must ensure and monitor**
1273 **effective, structured hand-over processes to facilitate both**
1274 **continuity of care and patient safety.**

1275
1276 **VI.B.3. Programs must ensure that fellows are competent in communicating**
1277 **with team members in the hand-over process.**

1278
1279 **VI.B.4. The sponsoring institution must ensure the availability of schedules**
1280 **that inform all members of the health care team of attending**
1281 **physicians and fellows currently responsible for each patient's care.**

1282
1283 **VI.C. Alertness Management/Fatigue Mitigation**

1284
1285 **VI.C.1. The program must:**

1286
1287 **VI.C.1.a) educate all faculty members and fellows to recognize the**
1288 **signs of fatigue and sleep deprivation;**

1289
1290 **VI.C.1.b) educate all faculty members and fellows in alertness**
1291 **management and fatigue mitigation processes; and,**

1292
1293 **VI.C.1.c) adopt fatigue mitigation processes to manage the potential**
1294 **negative effects of fatigue on patient care and learning, such**
1295 **as naps or back-up call schedules.**

1296
1297 **VI.C.2. Each program must have a process to ensure continuity of patient**
1298 **care in the event that a fellow may be unable to perform his/her**
1299 **patient care duties.**

1300
1301 **VI.C.3. The sponsoring institution must provide adequate sleep facilities**
1302 **and/or safe transportation options for fellows who may be too**
1303 **fatigued to safely return home.**

1304
1305 **VI.D. Supervision of Fellows**

1306
1307 **VI.D.1. In the clinical learning environment, each patient must have an**
1308 **identifiable, appropriately-credentialed and privileged attending**
1309 **physician (or licensed independent practitioner as approved by each**
1310 **Review Committee) who is ultimately responsible for that patient's**
1311 **care.**

1312
1313 **VI.D.1.a) This information should be available to fellows, faculty**

1314 members, and patients.

1315

1316 **VI.D.1.b)** Fellows and faculty members should inform patients of their
1317 respective roles in each patient’s care.

1318

1319 **VI.D.2.** The program must demonstrate that the appropriate level of
1320 supervision is in place for all fellows who care for patients.

1321

1322 Supervision may be exercised through a variety of methods. Some
1323 activities require the physical presence of the supervising faculty
1324 member. For many aspects of patient care, the supervising
1325 physician may be a more advanced resident or fellow. Other
1326 portions of care provided by the fellow can be adequately
1327 supervised by the immediate availability of the supervising faculty
1328 member or resident physician, either in the institution, or by means
1329 of telephonic and/or electronic modalities. In some circumstances,
1330 supervision may include post-hoc review of fellow-delivered care
1331 with feedback as to the appropriateness of that care.

1332

1333 **VI.D.3.** Levels of Supervision

1334

1335 To ensure oversight of fellow supervision and graded authority and
1336 responsibility, the program must use the following classification of
1337 supervision:

1338

1339 **VI.D.3.a)** Direct Supervision – the supervising physician is physically
1340 present with the fellow and patient.

1341

1342 **VI.D.3.b)** Indirect Supervision:

1343

1344 **VI.D.3.b).(1)** with direct supervision immediately available – the
1345 supervising physician is physically within the hospital
1346 or other site of patient care, and is immediately
1347 available to provide Direct Supervision.

1348

1349 **VI.D.3.b).(2)** with direct supervision available – the supervising
1350 physician is not physically present within the hospital
1351 or other site of patient care, but is immediately
1352 available by means of telephonic and/or electronic
1353 modalities, and is available to provide Direct
1354 Supervision.

1355

1356 **VI.D.3.c)** Oversight – the supervising physician is available to provide
1357 review of procedures/encounters with feedback provided
1358 after care is delivered.

1359

1360 **VI.D.4.** The privilege of progressive authority and responsibility, conditional
1361 independence, and a supervisory role in patient care delegated to
1362 each fellow must be assigned by the program director and faculty
1363 members.

- 1364
1365 **VI.D.4.a)** **The program director must evaluate each fellow’s abilities**
1366 **based on specific criteria. When available, evaluation should**
1367 **be guided by specific national standards-based criteria.**
1368
- 1369 **VI.D.4.b)** **Faculty members functioning as supervising physicians**
1370 **should delegate portions of care to fellows, based on the**
1371 **needs of the patient and the skills of the fellows.**
1372
- 1373 **VI.D.4.c)** **Senior residents or fellows should serve in a supervisory role**
1374 **of junior residents in recognition of their progress toward**
1375 **independence, based on the needs of each patient and the**
1376 **skills of the individual resident or fellow.**
1377
- 1378 **VI.D.5.** **Programs must set guidelines for circumstances and events in**
1379 **which fellows must communicate with appropriate supervising**
1380 **faculty members, such as the transfer of a patient to an intensive**
1381 **care unit, or end-of-life decisions.**
1382
- 1383 **VI.D.5.a)** **Each fellow must know the limits of his/her scope of**
1384 **authority, and the circumstances under which he/she is**
1385 **permitted to act with conditional independence.**
1386
- 1387 **VI.D.5.a).(1)** **In particular, PGY-1 residents should be supervised**
1388 **either directly or indirectly with direct supervision**
1389 **immediately available.**
1390
- 1391 **VI.D.6.** **Faculty supervision assignments should be of sufficient duration to**
1392 **assess the knowledge and skills of each fellow and delegate to**
1393 **him/her the appropriate level of patient care authority and**
1394 **responsibility.**
1395
- 1396 **VI.E.** **Clinical Responsibilities**
1397
- 1398 **The clinical responsibilities for each fellow must be based on PGY-level,**
1399 **patient safety, fellow education, severity and complexity of patient**
1400 **illness/condition and available support services.**
1401
- 1402 **VI.F.** **Teamwork**
1403
- 1404 **Fellows must care for patients in an environment that maximizes effective**
1405 **communication. This must include the opportunity to work as a member of**
1406 **effective interprofessional teams that are appropriate to the delivery of care**
1407 **in the specialty.**
1408
- 1409 **VI.G.** **Fellow Duty Hours**
1410
- 1411 **VI.G.1.** **Maximum Hours of Work per Week**
1412
- 1413 **Duty hours must be limited to 80 hours per week, averaged over a**

1414 four-week period, inclusive of all in-house call activities and all
1415 moonlighting.
1416
1417 **VI.G.1.a) Duty Hour Exceptions**
1418
1419 **A Review Committee may grant exceptions for up to 10% or a**
1420 **maximum of 88 hours to individual programs based on a**
1421 **sound educational rationale.**
1422
1423 *The Review Committee for Internal Medicine will not consider*
1424 *requests for exceptions to the 80-hour limit to the fellows' work*
1425 *week.*
1426
1427 **VI.G.1.a).(1) In preparing a request for an exception the program**
1428 **director must follow the duty hour exception policy**
1429 **from the ACGME Manual on Policies and Procedures.**
1430
1431 **VI.G.1.a).(2) Prior to submitting the request to the Review**
1432 **Committee, the program director must obtain approval**
1433 **of the institution's GMEC and DIO.**
1434
1435 **VI.G.2. Moonlighting**
1436
1437 **VI.G.2.a) Moonlighting must not interfere with the ability of the fellow**
1438 **to achieve the goals and objectives of the educational**
1439 **program.**
1440
1441 **VI.G.2.b) Time spent by fellows in Internal and External Moonlighting**
1442 **(as defined in the ACGME Glossary of Terms) must be**
1443 **counted towards the 80-hour Maximum Weekly Hour Limit.**
1444
1445 **VI.G.2.c) PGY-1 residents are not permitted to moonlight.**
1446
1447 **VI.G.3. Mandatory Time Free of Duty**
1448
1449 **Fellows must be scheduled for a minimum of one day free of duty**
1450 **every week (when averaged over four weeks). At-home call cannot**
1451 **be assigned on these free days.**
1452
1453 **VI.G.4. Maximum Duty Period Length**
1454
1455 **VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in**
1456 **duration.**
1457
1458 **VI.G.4.b) Duty periods of PGY-2 residents and above may be**
1459 **scheduled to a maximum of 24 hours of continuous duty in**
1460 **the hospital. Programs must encourage fellows to use**
1461 **alertness management strategies in the context of patient**
1462 **care responsibilities. Strategic napping, especially after 16**
1463 **hours of continuous duty and between the hours of 10:00**

- 1464 p.m. and 8:00 a.m., is strongly suggested.
- 1465
- 1466 **VI.G.4.b).(1)** It is essential for patient safety and fellow education
- 1467 that effective transitions in care occur. Fellows may be
- 1468 allowed to remain on-site in order to accomplish these
- 1469 tasks; however, this period of time must be no longer
- 1470 than an additional four hours.
- 1471
- 1472 **VI.G.4.b).(2)** Fellows must not be assigned additional clinical
- 1473 responsibilities after 24 hours of continuous in-house
- 1474 duty.
- 1475
- 1476 **VI.G.4.b).(3)** In unusual circumstances, fellows, on their own
- 1477 initiative, may remain beyond their scheduled period
- 1478 of duty to continue to provide care to a single patient.
- 1479 Justifications for such extensions of duty are limited
- 1480 to reasons of required continuity for a severely ill or
- 1481 unstable patient, academic importance of the events
- 1482 transpiring, or humanistic attention to the needs of a
- 1483 patient or family.
- 1484
- 1485 **VI.G.4.b).(3).(a)** Under those circumstances, the fellow must:
- 1486
- 1487 **VI.G.4.b).(3).(a).(i)** appropriately hand over the care of all
- 1488 other patients to the team responsible
- 1489 for their continuing care; and,
- 1490
- 1491 **VI.G.4.b).(3).(a).(ii)** document the reasons for remaining to
- 1492 care for the patient in question and
- 1493 submit that documentation in every
- 1494 circumstance to the program director.
- 1495
- 1496 **VI.G.4.b).(3).(b)** The program director must review each
- 1497 submission of additional service, and track
- 1498 both individual fellow and program-wide
- 1499 episodes of additional duty.
- 1500
- 1501 **VI.G.5.** **Minimum Time Off between Scheduled Duty Periods**
- 1502
- 1503 **VI.G.5.a)** PGY-1 residents should have 10 hours, and must have eight
- 1504 hours, free of duty between scheduled duty periods.
- 1505
- 1506 **VI.G.5.b)** Intermediate-level residents should have 10 hours free of
- 1507 duty, and must have eight hours between scheduled duty
- 1508 periods. They must have at least 14 hours free of duty after 24
- 1509 hours of in-house duty.
- 1510

Internal medicine subspecialty fellows are considered to be in the final years of education.

1514 **VI.G.5.c)** Residents in the final years of education must be prepared to
1515 enter the unsupervised practice of medicine and care for
1516 patients over irregular or extended periods.
1517

1518 Internal medicine subspecialty fellows are considered to be in the
1519 final years of education.
1520

1521 **VI.G.5.c).(1)** This preparation must occur within the context of the
1522 **80-hour, maximum duty period length, and one-day-**
1523 **off-in-seven standards. While it is desirable that**
1524 **fellows in their final years of education have eight**
1525 **hours free of duty between scheduled duty periods,**
1526 **there may be circumstances when these fellows must**
1527 **stay on duty to care for their patients or return to the**
1528 **hospital with fewer than eight hours free of duty.**
1529

1530 **VI.G.5.c).(1).(a)** Circumstances of return-to-hospital activities
1531 with fewer than eight hours away from the
1532 hospital by fellows in their final years of
1533 education must be monitored by the program
1534 director.
1535

1536 *VI.G.5.c).(1).(b)* In unusual circumstances, fellows may remain
1537 beyond their scheduled period of duty or return
1538 after their scheduled period of duty to provide care
1539 to a single patient. Justifications for such
1540 extensions of duty are limited to reasons of
1541 required continuity of care for a severely ill or
1542 unstable patient, academic importance of the
1543 events transpiring, or humanistic attention to the
1544 needs of the patient or family. Such episodes
1545 should be rare, must be of the fellows' own
1546 initiative, and need not initiate a new 'off-duty
1547 period' nor require a change in the scheduled 'off-
1548 duty period.'
1549

1550 *VI.G.5.c).(1).(c)* Under such circumstances, the fellow must
1551 appropriately hand over care of all other patients to
1552 the team responsible for their continuing care, and
1553 document the reasons for remaining or returning to
1554 care for the patient in question and submit that
1555 documentation to the program director.
1556

1557 *VI.G.5.c).(1).(d)* The program director must review each submission
1558 of additional service and track both individual
1559 fellows' and program-wide episodes of additional
1560 duty.
1561

1562 **VI.G.6. Maximum Frequency of In-House Night Float**
1563

1564 **Fellows must not be scheduled for more than six consecutive nights**
1565 **of night float.**

1566
1567 **VI.G.7. Maximum In-House On-Call Frequency**

1568
1569 **PGY-2 residents and above must be scheduled for in-house call no**
1570 **more frequently than every-third-night (when averaged over a four-**
1571 **week period).**

1572
1573 *VI.G.7.a) ~~Internal Medicine residency programs are~~ fellowships must not*
1574 *~~allowed to average in-house call over a four-week period.~~*

1575
1576 **VI.G.8. At-Home Call**

1577
1578 **VI.G.8.a) Time spent in the hospital by fellows on at-home call must**
1579 **count towards the 80-hour maximum weekly hour limit. The**
1580 **frequency of at-home call is not subject to the every-third-**
1581 **night limitation, but must satisfy the requirement for one-day-**
1582 **in-seven free of duty, when averaged over four weeks.**

1583
1584 **VI.G.8.a).(1) At-home call must not be so frequent or taxing as to**
1585 **preclude rest or reasonable personal time for each**
1586 **fellow.**

1587
1588 **VI.G.8.b) Fellows are permitted to return to the hospital while on at-**
1589 **home call to care for new or established patients. Each**
1590 **episode of this type of care, while it must be included in the**
1591 **80-hour weekly maximum, will not initiate a new “off-duty**
1592 **period”.**

1593
1594 **VII. Innovative Projects**

1595
1596 **Requests for innovative projects that may deviate from the institutional, common**
1597 **and/or specialty specific program requirements must be approved in advance by**
1598 **the Review Committee. In preparing requests, the program director must follow**
1599 **Procedures for Approving Proposals for Innovative Projects located in the ACGME**
1600 **Manual on Policies and Procedures. Once a Review Committee approves a**
1601 **project, the sponsoring institution and program are jointly responsible for the**
1602 **quality of education offered to fellows for the duration of such a project.**

1603
1604 *******

1605
1606 **ACGME Approved: February 5, 2011 Effective: July 1, 2012**