

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Clinical Cardiac Electrophysiology (Internal Medicine)**
3

4 **One-year 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 and fellowship programs are essential dimensions of the**
12 **transformation of the medical student to the independent practitioner along**
13 **the continuum of medical education. They are physically, emotionally, and**
14 **intellectually demanding, and require longitudinally-concentrated effort on**
15 **the part of the resident or fellow.**
16

17 **The specialty education of physicians to practice independently is**
18 **experiential, and necessarily occurs within the context of the health care**
19 **delivery system. Developing the skills, knowledge, and attitudes leading to**
20 **proficiency in all the domains of clinical competency requires the resident**
21 **and fellow physician to assume personal responsibility for the care of**
22 **individual patients. For the resident and fellow, the essential learning**
23 **activity is interaction with patients under the guidance and supervision of**
24 **faculty members who give value, context, and meaning to those**
25 **interactions. As residents and fellows gain experience and demonstrate**
26 **growth in their ability to care for patients, they assume roles that permit**
27 **them to exercise those skills with greater independence. This concept—**
28 **graded and progressive responsibility—is one of the core tenets of**
29 **American graduate medical education. Supervision in the setting of**
30 **graduate medical education has the goals of assuring the provision of safe**
31 **and effective care to the individual patient; assuring each resident's and**
32 **fellow's development of the skills, knowledge, and attitudes required to**
33 **enter the unsupervised practice of medicine; and establishing a foundation**
34 **for continued professional growth.**
35

36 **Int.B. Clinical cardiac electrophysiology encompasses the special knowledge and skills**
37 **required of cardiologists who care for patients with complex cardiac rhythm**
38 **disorders, particularly those receiving diagnostic and therapeutic interventional**
39 **electrophysiologic procedures. Clinical cardiac electrophysiology is the practice**
40 **of techniques that focus on diagnosis and treatment of atrial and ventricular**
41 **arrhythmias, including the use of cardiac implantable electrical devices, and the**
42 **application of other interventional ablative techniques and pharmacologic**
43 **treatments. A subspecialty educational program in Clinical cardiac**
44 **electrophysiology fellowships provide advance education to allow a fellow to**
45 **acquire competency in the subspecialty with sufficient expertise to act as an**
46 **independent consultant. ~~must function as an integral component of an ACGME-~~**
47 **~~accredited subspecialty fellowship in cardiovascular disease and be organized to~~**
48 **~~provide training and experience at a sufficient level for fellows to acquire the~~**
49 **~~competency of a specialist in the field.~~**
50

51 **Int.C. ~~An accredited fellowship~~ The educational program in clinical cardiac**

52 electrophysiology must ~~provide~~ be 12 months of supervised graduate medical
53 education in length.

54
55 **I. Institutions**

56
57 **I.A. Sponsoring Institution**

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

62
63 **The sponsoring institution and the program must ensure that the program**
64 **director has sufficient protected time and financial support for his or her**
65 **educational and administrative responsibilities to the program.**

66
67 I.A.1. A clinical cardiac electrophysiology fellowship must function as an integral
68 part of an ACGME-accredited-fellowship-program in cardiovascular
69 disease.

70
71 I.A.2. *The sponsoring institution must:*

72
73 I.A.2.a) *provide ~~ensure~~ the program director with adequate support for the*
74 *administrative activities of the ~~internal medicine subspecialty~~*
75 *~~program-fellowship~~.*

76
77 I.A.2.a).(1) *The program director must not be required to generate*
78 *clinical or other income to provide this administrative*
79 *support.*

80
81 I.A.2.a).(2) *It is suggested this support be 25-50% of the program*
82 *director's salary, or protected time, depending on the size*
83 *of the program.*

84
85 I.A.3. *The sponsoring institution and participating sites must:*

86
87 I.A.3.a) *demonstrate that there is a culture of continuous quality*
88 *improvement in the areas of patient care, patient safety, and*
89 *education;*

90
91 I.A.3.b) *demonstrate a commitment to quality patient-centered care and*
92 *safety, education, ~~research~~ and scholarship sufficient to support*
93 *the fellowship program; and,*

94
95 I.A.3.c) *share appropriate inpatient and outpatient faculty performance*
96 *data with the program director.*

97
98 I.A.1.a) *~~provide fellow compensation, and benefits, faculty, facilities, and~~*
99 *~~resources for education, clinical care, and research required for~~*
100 *~~accreditation~~;*

101
102 I.A.3.d) *~~notify the Review Committee within 60 days of changes in~~*

- 103 *institutional governance, affiliation, or resources that affect the*
104 *educational program as outlined in the Institutional Requirements;*
105 *and*
106
107 I.A.3.e) *provide fellowship positions in each training program that do not*
108 *number the number of accredited training; in the program; and*
109
110 **I.B. Participating Sites**
111
112 **I.B.1. There must be a program letter of agreement (PLA) between the**
113 **program and each participating site providing a required**
114 **assignment. The PLA must be renewed at least every five years.**
115
116 **The PLA should:**
117
118 **I.B.1.a) identify the faculty who will assume both educational and**
119 **supervisory responsibilities for fellows;**
120
121 **I.B.1.b) specify their responsibilities for teaching, supervision, and**
122 **formal evaluation of fellows, as specified later in this**
123 **document;**
124
125 **I.B.1.c) specify the duration and content of the educational**
126 **experience; and,**
127
128 **I.B.1.d) state the policies and procedures that will govern fellow**
129 **education during the assignment.**
130
131 **I.B.2. The program director must submit any additions or deletions of**
132 **participating sites routinely providing an educational experience,**
133 **required for all fellows, of one month full time equivalent (FTE) or**
134 **more through the Accreditation Council for Graduate Medical**
135 **Education (ACGME) Accreditation Data System (ADS).**
136
137 **II. Program Personnel and Resources**
138
139 **II.A. Program Director**
140
141 **II.A.1. There must be a single program director with authority and**
142 **accountability for the operation of the program. The sponsoring**
143 **institution's GMEC must approve a change in program director.**
144 **After approval, the program director must submit this change to the**
145 **ACGME via the ADS.**
146
147 **II.A.2. Qualifications of the program director must include:**
148
149 **II.A.2.a) requisite specialty expertise and documented educational**
150 **and administrative experience acceptable to the Review**
151 **Committee;**
152
153 **II.A.2.a).(1) The program director must have at least five years of**

- 154 participation as an active faculty member in an ACGME-
 155 accredited internal medicine cardiovascular disease
 156 fellowship or clinical cardiac electrophysiology fellowship.
 157
- 158 **II.A.2.b) current certification in the subspecialty by the American**
 159 **Board of Internal Medicine (ABIM), or subspecialty**
 160 **qualifications that are acceptable to the Review Committee;**
 161 **and**
 162
- 163 **II.A.2.b).(1) The Review Committee only accepts current ABIM**
 164 **certification in clinical cardiac electrophysiology.**
 165
- 166 **II.A.2.c) current medical licensure and appropriate medical staff**
 167 **appointment.**
 168
- 169 **II.A.3. The program director must administer and maintain an educational**
 170 **environment conducive to educating the fellows in each of the**
 171 **ACGME competency areas. The program director must:**
 172
- 173 **II.A.3.a) prepare and submit all information required and requested by**
 174 **the ACGME;**
 175
- 176 **II.A.3.b) be familiar with and oversee compliance with ACGME and**
 177 **Review Committee policies and procedures as outlined in the**
 178 **ACGME Manual of Policies and Procedures;**
 179
- 180 **II.A.3.c) obtain review and approval of the sponsoring institution's**
 181 **GMEC/DIO before submitting to the ACGME information or**
 182 **requests for the following:**
 183
- 184 **II.A.3.c).(1) all applications for ACGME accreditation of new**
 185 **programs;**
 186
- 187 **II.A.3.c).(2) changes in fellow complement;**
 188
- 189 **II.A.3.c).(3) major changes in program structure or length of**
 190 **training;**
 191
- 192 **II.A.3.c).(4) progress reports requested by the Review Committee;**
 193
- 194 **II.A.3.c).(5) responses to all proposed adverse actions;**
 195
- 196 **II.A.3.c).(6) requests for increases or any change to fellow duty**
 197 **hours;**
 198
- 199 **II.A.3.c).(7) voluntary withdrawals of ACGME-accredited**
 200 **programs;**
 201
- 202 **II.A.3.c).(8) requests for appeal of an adverse action; and,**
 203
- 204 **II.A.3.c).(9) appeal presentations to a Board of Appeal or the**

- 205
206
207 **II.A.3.d)** **obtain DIO review and co-signature on all program**
208 **information forms, as well as any correspondence or**
209 **document submitted to the ACGME that addresses:**
210
211 **II.A.3.d).(1)** **program citations; and/or,**
212
213 **II.A.3.d).(2)** **requests for changes in the program that would have**
214 **significant impact, including financial, on the program**
215 **or institution.**
216
217 *II.A.3.e)* ensure that fellows' service responsibilities are limited to patients
218 for whom the teaching service has diagnostic and therapeutic
219 responsibility.
220
221 *II.A.3.f)* *dedicate an average of 20 hours per week of his or her*
222 *professional effort to the ~~internal medicine subspecialty program~~*
223 *fellowship, including with sufficient time for administration of the*
224 *program; ~~and receive institutional support for that administrative~~*
225 *time.*
226
227 *II.A.3.g)* *have a reporting relationship with the program director of the*
228 *cardiovascular disease program to ensure compliance with ~~the~~*
229 *ACGME accreditation standards; and,*
230
231 *II.A.3.h)* *be available ~~located~~ at the primary principal clinical site.*
232
233 **II.B. Faculty**
234
235 **II.B.1.** **There must be a sufficient number of faculty with documented**
236 **qualifications to instruct and supervise all fellows.**
237
238 **II.B.2.** **The faculty must devote sufficient time to the educational program**
239 **to fulfill their supervisory and teaching responsibilities and**
240 **demonstrate a strong interest in the education of fellows.**
241
242 **II.B.3.** **The physician faculty must have current certification in the**
243 **subspecialty by the American Board of Internal Medicine or possess**
244 **qualifications acceptable to the Review Committee.**
245
246 **II.B.4.** **The physician faculty must possess current medical licensure and**
247 **appropriate medical staff appointment.**
248
249 *II.B.5.* *The physician faculty must meet professional standards of ethical*
250 *behavior.*
251
252 **II.B.6.** **The faculty must establish and maintain an environment of inquiry and**
253 **scholarship with an active research component.**
254
255 **II.B.6.a)** **The faculty must regularly participate in organized clinical**

256 discussions, rounds, journal clubs, and conferences.
257
258 II.B.6.b) Some members of the faculty should also demonstrate
259 scholarship by one or more of the following:
260
261 II.B.6.b).(1) peer-reviewed funding;
262
263 II.B.6.b).(2) publication of original research or review articles in peer-
264 reviewed journals or chapters in textbooks;
265
266 II.B.6.b).(3) publication or presentation of case reports or clinical series
267 at local, regional, or national professional and scientific
268 society meetings; or,
269
270 II.B.6.b).(4) participation in national committees or educational
271 organizations.
272
273 II.B.6.c) Faculty should encourage and support fellows in scholarly
274 activities.
275
276 II.B.7. Key Clinical Faculty
277
278 In addition to the program director, each program must have at least one
279 Key Clinical Faculty (KCF). KCF are attending physicians who dedicate,
280 on average, 10 hours per week throughout the year to the training
281 education program. For programs with more than two fellows, ~~in the~~
282 ~~accredited portion of the training program, a ratio of KCF to fellows of at~~
283 ~~least 1:1 must be maintained~~ there must be at least one KCF for every
284 1.5 fellows.
285
286 II.B.7.a) Key Clinical Faculty Qualifications
287
288 II.B.7.a).(1) KCF must be active clinicians with ~~broad~~ knowledge of,
289 experience with, and commitment to clinical cardiac
290 electrophysiology as a discipline.
291
292 II.B.7.a).(2) KCF must have current ABIM certification in clinical cardiac
293 electrophysiology.
294
295 II.B.7.b) *Key Clinical Faculty Responsibilities*
296
297 II.B.7.b).(1) *In addition to the responsibilities of all individual faculty*
298 *members, the KCF ~~with and~~ the program director are*
299 *responsible for the planning, implementation, monitoring,*
300 *and evaluation of the fellows' clinical and research*
301 *education training.*
302
303 II.B.7.b).(2) ~~The majority~~ *At least 50 % of the KCF must demonstrate*
304 *evidence of productivity in ~~the~~ scholarship, specifically,*
305 *peer-reviewed funding; publication of original research,*
306 *review articles, editorials, or case reports in peer-reviewed*

- 307 *journals; or chapters in textbooks, as defined in II.B.5.b.(1),*
308 *or (2) above*
309
- 310 II.B.8. *All-Clinical faculty members should participate in ~~prescribed~~ faculty*
311 *development programs designed to enhance the effectiveness of their*
312 *teaching.*
313
- 314 II.B.9. Access to faculty with expertise in pharmacology, radiation safety, and
315 research laboratories is suggested.
316
- 317 **II.C. Other Program Personnel**
318
- 319 **The institution and the program must jointly ensure the availability of all**
320 **necessary professional, technical, and clerical personnel for the effective**
321 **administration of the program.**
322
- 323 II.C.1. *There must be services available from other health care professionals,*
324 *including dietitians, language interpreters, nurses, occupational*
325 *therapists, physical therapists, and social workers.*
326
- 327 II.C.2. *There must be ensure the availability of appropriate and timely*
328 *consultation from other specialties.*
329
- 330 **II.D. Resources**
331
- 332 **The institution and the program must jointly ensure the availability of**
333 **adequate resources for fellow education, as defined in the specialty**
334 **program requirements.**
335
- 336 II.D.1. *Space and Equipment*
337
- 338 *There must be space and equipment for the ~~educational~~ program,*
339 *including meeting rooms, ~~classrooms~~, examination rooms, computers,*
340 *visual and other educational aids, and work/study space.*
341
- 342 II.D.2. *Facilities*
343
- 344 II.D.2.a) *Inpatient and outpatient systems must be in place to prevent*
345 *fellows from performing routine clerical functions, including*
346 *scheduling tests and appointments, and retrieving records and*
347 *letters.*
348
- 349 II.D.2.b) *The sponsoring institution must provide the broad range of*
350 *facilities and clinical support services required to provide*
351 *comprehensive care of adult patients. ~~Fellows must have clinical~~*
352 *experiences in efficient, effective ambulatory and inpatient care*
353 *settings.*
354
- 355 II.D.2.c) *Fellows must have access to a lounge facility during assigned*
356 *duty hours.*
357

358 II.D.2.d) ~~When fellows are assigned night duty in the hospital, assigned~~
359 ~~night duty, or called in from home, they must be provided with on-~~
360 ~~call facilities that are convenient and that afford privacy, safety,~~
361 ~~and a restful environment with a secure space for their~~
362 ~~belongings.~~

364 II.D.3. Laboratory Services

365
366 II.D.3.a) The following must be present at the primary clinical site:

367
368 II.D.3.a).(1) an electrophysiology laboratory ~~must be~~ equipped with
369 cardiac fluoroscopic equipment, recording devices,
370 programmable stimulator, and resuscitative equipment;
371 and,

372
373 II.D.3.a).(2) cardiac radionuclide laboratories.

374
375 II.D.3.b) Laboratories other than those located at the primary ~~training~~
376 ~~clinical site may that~~ participate in the educational program ~~under~~
377 ~~the following conditions. The participating electrophysiology~~
378 ~~laboratory must be~~ equipped with cardiac fluoroscopic equipment,
379 recording devices, programmable stimulator, and resuscitative
380 equipment.

381
382 II.D.4. Other Facilities, Resources, or Support Services

383
384 The following must be present at the primary ~~training~~ clinical site:

385
386 II.D.4.a) an active cardiac surgery program;

387
388 II.D.4.b) a cardiac intensive care unit; and,

389
390 II.D.4.c) a cardiac surgery intensive care unit.

391
392 II.D.5. *Medical Records*

393
394 Access to an electronic health record should be provided. In the absence
395 of an existing electronic health record, institutions must demonstrate
396 institutional commitment to its development and progress toward its
397 implementation.

398
399 II.D.6. Patient Population

400
401 II.D.6.a) The patient population must have a variety of clinical problems
402 and stages of diseases.

403
404 II.D.6.b) There must be patients of each gender—both sexes, with a broad
405 age range, including geriatric patients.

406
407 II.D.6.c) A sufficient number of patients must be available to enable ensure
408 adequate inpatient and ambulatory experience for each fellow to

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achieve the required educational outcomes.

II.E. Medical Information Access

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

III. Fellow Appointments

III.A. Eligibility Criteria

Each fellow must successfully complete an ACGME-accredited specialty program and/or meet other eligibility criteria as specified by the Review Committee. The program must document that each fellow has met the eligibility criteria.

III.A.1. ~~Fellows entering the program~~ Prior to appointment in the fellowship, ~~program fellows~~ should have completed a three-year ACGME-accredited cardiovascular disease program.

III.A.2. Fellows from non-ACGME-accredited internal medicine education programs must have completed at least three years of cardiovascular disease education prior to starting the fellowship.

III.A.3. ~~The program director must inform non-ACGME-trained applicants from non-ACGME-accredited programs, prior to appointment, and in writing, of the ABIM policies and procedures that may will affect the fellow's their eligibility for ABIM certification.~~

III.A.4. When averaged over any five-year period, a minimum of 75% of fellows in each ~~subspecialty training~~ program must be graduates of an ACGME-accredited cardiovascular disease program.

III.B. Number of Fellows

The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of fellows appointed to the program.

~~III.B.1. The minimum number of fellow positions in the training program fellowship must not be less than the number of accredited training years in the program.~~

IV. Educational Program

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

IV.A.1. Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills

460 and competencies to fellow and faculty annually, in either written or
461 electronic form. These skills and competencies should be reviewed
462 by the fellow at the start of each rotation.

463
464 **IV.A.2. ACGME Competencies**

465
466 **The program must integrate the following ACGME competencies**
467 **into the curriculum:**

468
469 **IV.A.2.a) Patient Care**

470
471 **Fellows must be able to provide patient care that is**
472 **compassionate, appropriate, and effective for the treatment of**
473 **health problems and the promotion of health. Fellows:**

474
475 *IV.A.2.a).(1) must demonstrate competence in the practice of health*
476 *promotion, disease prevention, diagnosis, care, and*
477 *treatment of ~~men and women~~ patients of each gender,*
478 *from adolescence to old age, during health and all stages*
479 *of illness.*

480
481 *IV.A.2.a).(2) ~~must have formal instruction, clinical experience, and must~~*
482 *demonstrate competence in the prevention, evaluation,*
483 *and management of both inpatients and outpatients with*
484 *the following disorders:*

485
486 *IV.A.2.a).(2).(a) aborted sudden cardiac arrest;*

487
488 *IV.A.2.a).(2).(b) arrhythmias resulting from pharmacologic*
489 *interactions;*

490
491 *IV.A.2.a).(2).(c) disorders of cardiac rhythm, ~~including but not~~*
492 *limited to: sinus node dysfunction; atrioventricular*
493 *(AV) and intraventricular block; and*
494 *supraventricular and ventricular tachyarrhythmias;*

495
496 *IV.A.2.a).(2).(d) increased risk for sudden cardiac arrest;*

497
498 *IV.A.2.a).(2).(e) metabolic derangements resulting in arrhythmia;*

499
500 *IV.A.2.a).(2).(f) need for acute or chronic anticoagulations;*

501
502 *IV.A.2.a).(2).(g) palpitations;*

503
504 *IV.A.2.a).(2).(h) prolonged QT syndrome;*

505
506 *IV.A.2.a).(2).(i) syncope; and,*

507
508 *IV.A.2.a).(2).(j) Wolff-Parkinson-White (WPW) syndrome;*

509
510 *IV.A.2.a).(3) ~~must have formal instruction, clinical experience, and must~~*

511		demonstrate competence in:
512		
513	IV.A.2.a).(3).(a)	the care of patients in the cardiac care unit, emergency room, or other intensive care settings;
514		
515		
516	IV.A.2.a).(3).(b)	the care of the patients before and after an electrophysiologic procedure;
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518		
519	IV.A.2.a).(3).(c)	the care of patients with post-operative arrhythmias;
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521		
522	IV.A.2.a).(3).(d)	the care and monitoring of patients with ICDs and biventricular ICDs; and,
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524		
525	IV.A.2.a).(3).(e)	the care and monitoring of patients with temporary and permanent pacemakers of all types including biventricular pacemakers.
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528		
529	IV.A.2.a).(4)	must have formal instruction, clinical experience, and must demonstrate competence in the performance of:
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531		
532	IV.A.2.a).(4).(a)	noninvasive testing relevant to arrhythmia diagnoses and treatment;
533		
534		
535	IV.A.2.a).(4).(b)	invasive electrophysiologic testing;
536		
537	IV.A.2.a).(4).(c)	a minimum of 150 electrophysiologic procedures <u>(each fellow must perform a minimum of 150 with at least 75 studies involving patients with supraventricular arrhythmias); and,</u>
538		
539		
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541		
542	IV.A.2.a).(4).(d)	a minimum of 25 electrophysiological evaluations of implantable antiarrhythmic devices <u>(each fellow must perform a minimum of 25).</u>
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546	IV.A.2.a).(5)	must <u>demonstrate</u> competence in:
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548	IV.A.2.a).(5).(a)	a minimum of 75 catheter ablative procedures, including post-diagnostic testing <u>(each fellow must perform a minimum of 75);</u>
549		
550		
551		
552	IV.A.2.a).(5).(b)	a mix of AV nodal reentrant tachycardia and accessory pathway modification, atrial tachycardia and atrial flutter, AV junctional ablation and modification, and ventricular tachycardia ablation;
553		
554		
555		
556		
557	IV.A.2.a).(5).(c)	a minimum of 30 atrial fibrillation ablative procedures; as minimal required training; and
558		
559		
560	IV.A.2.a).(5).(d)	electrode catheter introduction;
561		

562	IV.A.2.a).(5).(e)	electrode catheter positioning in the atria,
563		ventricles, coronary sinus, His bundle area, and
564		pulmonary artery;
565		
566	IV.A.2.a).(5).(f)	implantation of cardioverter/defibrillators and
567		pacemakers, <u>including</u> :
568		
569	IV.A.2.a).(5).(f).(i)	participation in a minimum of 25 ICD
570		implantations;
571		
572	IV.A.2.a).(5).(f).(ii)	participation in a minimum of 30 ICD or
573		pacemaker revisions or replacements;
574		
575	IV.A.2.a).(5).(f).(iii)	participation in a minimum of 25 dual-
576		chamber pacemaker implantations;
577		
578	IV.A.2.a).(5).(f).(iv)	participation in a minimum of 25 CRT (either
579		pacing or defibrillation) implantations;
580		
581	IV.A.2.a).(5).(f).(v)	device interrogation and programming, with
582		a minimum of 100 ICDs and 100
583		pacemakers;
584		
585	IV.A.2.a).(5).(f).(vi)	noninvasive programmed stimulation for
586		arrhythmia induction through the device;
587		
588	IV.A.2.a).(5).(f).(vii)	defibrillation threshold testing; and,
589		
590	IV.A.2.a).(5).(f).(viii)	final prescription of anti-tachycardia pacing
591		and defibrillation therapies.
592		
593	IV.A.2.a).(5).(g)	measurement and interpretation of data;
594		
595	IV.A.2.a).(5).(h)	recording techniques, including an understanding of
596		amplifiers, filters, and signal processors;
597		
598	IV.A.2.a).(5).(i)	experience with at least 10 trans-septal
599		catheterization procedures is suggested as minimal
600		required training;
601		
602	IV.A.2.a).(5).(j)	stimulating techniques to obtain conduction times
603		and refractory periods and to initiate and terminate
604		tachycardias; and,
605		
606	IV.A.2.a).(5).(k)	therapeutic catheter ablation procedures.
607		
608	IV.A.2.a).(6)	must have formal instruction, clinical experience, and must
609		demonstrate competence in the interpretation of:
610		
611	IV.A.2.a).(6).(a)	activation sequence mapping recordings;
612		

- 613 IV.A.2.a).(6).(b) advanced electrocardiographic methods of risk
614 stratification;
615
616 IV.A.2.a).(6).(c) continuous in-hospital electrocardiogram (ECG)
617 recording;
618
619 IV.A.2.a).(6).(d) ~~electrocardiograms~~ ECG and ambulatory ECG
620 recordings, including event recorders;
621
622 IV.A.2.a).(6).(e) invasive intracardiac electrophysiologic studies,
623 including endocardial electrogram recording;
624
625 IV.A.2.a).(6).(f) relevant imaging studies, including chest
626 radiography;
627
628 IV.A.2.a).(6).(g) remote device transmissions;
629
630 IV.A.2.a).(6).(h) stress test ECG recordings;
631
632 IV.A.2.a).(6).(i) tilt testing; and,
633
634 IV.A.2.a).(6).(j) transtelephonic ECG readings.
635

636 **IV.A.2.b)**

Medical Knowledge

637
638 **Fellows must demonstrate knowledge of established and**
639 **evolving biomedical, clinical, epidemiological and social-**
640 **behavioral sciences, as well as the application of this**
641 **knowledge to patient care. Fellows:**
642

- 643 IV.A.2.b).(1) must demonstrate knowledge of the scientific method of
644 problem solving and evidence-based decision making;
645 commitment to lifelong learning, and an attitude of caring
646 that is derived from humanistic and professional values
647
648 IV.A.2.b).(2) must ~~develop~~ demonstrate a knowledge understanding of
649 indications, contraindications, limitations, complications,
650 techniques, and interpretation of results of those diagnostic
651 and therapeutic procedures integral to the ~~clinical cardiac~~
652 ~~electrophysiology~~ discipline, including the appropriate
653 indications for and use of screening tests/procedures.
654
655 IV.A.2.b).(3) must demonstrate knowledge of ~~the following content~~
656 ~~areas:~~
657
658 IV.A.2.b).(3).(a) anticoagulation;
659
660 IV.A.2.b).(3).(b) arrhythmia control;
661
662 IV.A.2.b).(3).(c) basic cardiac electrophysiology, including but not
663 limited to genesis of arrhythmias, normal and

664		abnormal electrophysiologic responses, autonomic influences, effects of ischemia, drugs, and other interventions;
665		
666		
667		
668	IV.A.2.b).(3).(d)	device management;
669		
670	IV.A.2.b).(3).(e)	epidemiology of arrhythmias;
671		
672	IV.A.2.b).(3).(f)	the genetic basis of pathological arrhythmias;
673		
674	IV.A.2.b).(3).(g)	medical management of acute and chronic heart failure associated with left ventricular systolic dysfunction;
675		
676		
677		
678	IV.A.2.b).(3).(h)	radiation physics, biology, and safety related to the use of x-ray imaging equipment; and,
679		
680		
681	IV.A.2.b).(3).(i)	the role of randomized clinical trials and registry experiences in clinical decision making.
682		
683		
684	IV.A.2.c)	Practice-based Learning and Improvement
685		
686		Fellows are expected to develop skills and habits to be able to meet the following goals:
687		
688		
689	IV.A.2.c).(1)	systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; and,
690		
691		
692		
693	IV.A.2.c).(2)	locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.
694		
695		
696		
697	IV.A.2.d)	Interpersonal and Communication Skills
698		
699		Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.
700		
701		
702		
703		
704	IV.A.2.e)	Professionalism
705		
706		Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.
707		
708		
709		
710	<i>IV.A.2.e).(1)</i>	<i>Fellows must demonstrate:</i>
711		
712	<i>IV.A.2.e).(1).(a)</i>	<u><i>high standards of ethical behavior, including maintaining appropriate professional boundaries and relationships with other physicians and other</i></u>
713		
714		

715		<u>health care team members, and avoiding conflicts</u>
716		<u>of interest; and,</u>
717		
718	IV.A.2.e).(1).(b)	<i>a commitment to lifelong learning, and an attitude</i>
719		<i>of caring derived from humanistic and professional</i>
720		<i>values.</i>
721		
722	IV.A.2.e).(1).(c)	<u>competence in</u> providing consultation to physicians
723		in other disciplines.
724		
725	IV.A.2.f)	Systems-based Practice
726		
727		Fellows must demonstrate an awareness of and
728		responsiveness to the larger context and system of health
729		care, as well as the ability to call effectively on other
730		resources in the system to provide optimal health care.
731		
732	IV.A.3.	<u>Curriculum Organization and Fellow Experiences</u>
733		
734	IV.A.3.a)	All 12 months must include appropriate protected, block or
735		concurrent time, for fellow's research. All 12 months must include
736		clinical experiences and appropriate protected (block or
737		concurrent) time for research.
738		
739	IV.A.3.b)	<u>Fellows must participate in training using simulation.</u>
740		
741	IV.A.3.c)	<u>The core curriculum must include a didactic program based upon</u>
742		<u>the core knowledge content in the subspecialty area.</u>
743		
744	IV.A.3.c).(1)	<u>The program must afford each fellow an opportunity to</u>
745		<u>review topics covered in conferences that they were</u>
746		<u>unable to attend.</u>
747		
748	IV.A.3.c).(2)	<u>Fellows must participate in clinical case conferences,</u>
749		<u>journal clubs, research conferences, and morbidity and</u>
750		<u>mortality or quality improvement conference.</u>
751		
752	IV.A.3.c).(3)	<u>All core conferences must have at least one faculty</u>
753		<u>member present, and must be scheduled as to assure</u>
754		<u>peer-peer and peer-faculty interaction.</u>
755		
756	IV.A.3.d)	<u>Fellows must be instructed in practice management relevant to</u>
757		<u>clinical cardiac electrophysiology.</u>
758		
759	IV.A.3.e)	<u>Fellows</u> must attend an outpatient program clinic must exist to
760		provide follow-up care for patients.
761		
762	IV.A.3.f)	Procedures and Technical Skills
763		
764	IV.A.3.f).(1)	<u>Direct faculty</u> supervision of procedures performed by each
765		fellow must occur until proficiency has been acquired and

766 *documented by the program director.*

767

768 IV.A.3.f).(2) ~~A skilled preceptor~~ Faculty members must be available to

769 teach and supervise the fellows in the performance and

770 interpretation of these procedures, which must be

771 documented in each fellow's record, giving including

772 indications, outcomes, diagnoses, and supervisor(s).

773

774 IV.A.3.f).(3) All fellows must:

775

776 | IV.A.3.f).(3).(a) participate in pre-procedural planning, including the

777 indications for the procedure and the selection of

778 the appropriate procedure or instruments;

779

780 IV.A.3.f).(3).(b) perform the critical technical manipulations of the

781 procedure;

782

783 | IV.A.3.f).(3).(c) demonstrate substantial involvement in post-

784 procedure care; and,

785

786 IV.A.3.f).(3).(d) be supervised by teaching faculty responsible for

787 the procedure.

788

789 **IV.B. Fellows' Scholarly Activities**

790

791 IV.B.1. ~~Fellows should participate in scholarly activity.~~ Each program must

792 provide an opportunity for fellows to participate in research or other

793 scholarly activities, including:

794

795 IV.B.1.a) a research project (with faculty mentorship); or

796

797 IV.B.1.b) participation with the faculty in the initiation and conduct of clinical

798 trials within the department; or,

799

800 IV.B.1.c) participation in quality assurance/quality improvement or process

801 improvement projects.

802

803 **V. Evaluation**

804

805 **V.A. Fellow Evaluation**

806

807 **V.A.1. Formative Evaluation**

808

809 **V.A.1.a) The faculty must evaluate fellow performance in a timely**

810 **manner.**

811

812 V.A.1.a).(1) The faculty must discuss evaluations with the fellow at

813 least every three months. ~~The faculty must discuss this~~

814 ~~evaluation with the fellow at the completion of the~~

815 ~~assignment.~~

816

817	V.A.1.a).(1).(a)	Fellow performance in the outpatient follow-up
818		clinic must be reviewed with them verbally and in
819		writing at least every three months.
820		
821	V.A.1.a).(2)	<u>Assessment of procedural competence should include a</u>
822		<u>formal evaluation process and not be based solely on a</u>
823		<u>minimum number of procedures performed.</u>
824		
825	V.A.1.b)	The program must:
826		
827	V.A.1.b).(1)	provide objective assessments of competence in
828		patient care, medical knowledge, practice-based
829		learning and improvement, interpersonal and
830		communication skills, professionalism, and systems-
831		based practice;
832		
833	V.A.1.b).(1).(a)	<u>Patient Care</u>
834		
835		<u>The program must assess the fellow in data</u>
836		<u>gathering, clinical reasoning, patient management,</u>
837		<u>and procedures in both the inpatient and outpatient</u>
838		<u>setting. This assessment must involve direct</u>
839		<u>observation of fellow-patient encounters.</u>
840		
841	V.A.1.b).(1).(a).(i)	<u>Each program must define a standard</u>
842		<u>criteria for proficiency competence for all</u>
843		<u>required and elective procedures.</u>
844		
845	V.A.1.b).(1).(a).(ii)	<u>The record of evaluation must include the</u>
846		<u>fellow's logbook or an equivalent method to</u>
847		<u>demonstrate that each fellow has achieved</u>
848		<u>competence in the performance of required</u>
849		<u>procedures.</u>
850		
851	V.A.1.b).(1).(b)	<u>Medical Knowledge</u>
852		
853		<u>The program must use an objective formative</u>
854		<u>assessment method. The same formative</u>
855		<u>assessment method must be administered at least</u>
856		<u>twice during the training program.</u>
857		
858	V.A.1.b).(1).(c)	<u>Practice-based Learning and Improvement</u>
859		
860		<u>The program must use performance data to assess</u>
861		<u>fellow in:</u>
862		
863	V.A.1.b).(1).(c).(i)	<u>application of evidence to patient care;</u>
864		
865	V.A.1.b).(1).(c).(ii)	<u>practice improvement;</u>
866		
867	V.A.1.b).(1).(c).(iii)	<u>teaching skills involving peers and patients;</u>

868		<u>and,</u>
869		
870	V.A. 1.b).(1).(c).(iv)	<u>scholarship.</u>
871		
872	V.A. 1.b).(1).(d)	<u>Interpersonal and Communication Skills</u>
873		
874		<u>The program must use both direct observation and</u>
875		<u>multi-source evaluation, including patients, peers</u>
876		<u>and non-physician team members, to assess fellow</u>
877		<u>performance in:</u>
878		
879	V.A. 1.b).(1).(d).(i)	<u>communication with patient and family;</u>
880		
881	V.A. 1.b).(1).(d).(ii)	<u>teamwork;</u>
882		
883	V.A. 1.b).(1).(d).(iii)	<u>communication with peers, including</u>
884		<u>transitions in care; and,</u>
885		
886	V.A. 1.b).(1).(d).(iv)	<u>record keeping.</u>
887		
888	V.A. 1.b).(1).(e)	<u>Professionalism</u>
889		
890		<u>The program must use multi-source evaluation,</u>
891		<u>including patients, peers, and non-physician team</u>
892		<u>members, to assess the fellow:</u>
893		
894	V.A. 1.b).(1).(e).(i)	<u>honesty and integrity;</u>
895		
896	V.A. 1.b).(1).(e).(ii)	<u>ability to meet professional responsibilities;</u>
897		
898	V.A. 1.b).(1).(e).(iii)	<u>ability to maintain appropriate professional</u>
899		<u>relationships with patients and colleagues;</u>
900		<u>and,</u>
901		
902	V.A. 1.b).(1).(e).(iv)	<u>commitment to self-improvement.</u>
903		
904	V.A. 1.b).(1).(f)	<u>Systems-based Practice</u>
905		
906		<u>The program must use multi-source evaluation,</u>
907		<u>including peers, and non-physician team members,</u>
908		<u>to assess the fellow's:</u>
909		
910	V.A. 1.b).(1).(f).(i)	<u>ability to provide care coordination,</u>
911		<u>including transition of care;</u>
912		
913	V.A. 1.b).(1).(f).(ii)	<u>ability to work in interdisciplinary teams;</u>
914		
915	V.A. 1.b).(1).(f).(iii)	<u>advocacy for quality of care; and,</u>
916		
917	V.A. 1.b).(1).(f).(iv)	<u>ability to identify system problems and</u>
918		<u>participate in improvement activities.</u>

- 919
- 920 V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients,
- 921 self, and other professional staff); and,
- 922
- 923 V.A.1.b).(3) provide each fellow with documented semiannual
- 924 evaluation of performance with feedback.
- 925
- 926 V.A.1.c) The evaluation of fellow performance must be accessible for
- 927 review by the fellows, in accordance with institutional policy.
- 928
- 929 V.A.2. Summative Evaluation
- 930
- 931 The program director must provide a summative evaluation for each
- 932 fellow upon completion of the program. This evaluation must
- 933 become part of the fellow's permanent record maintained by the
- 934 institution, and must be accessible for review by the fellow in
- 935 accordance with institutional policy. This evaluation must:
- 936
- 937 V.A.2.a) document the fellow's performance during their education;
- 938 and,
- 939
- 940 V.A.2.b) verify that the fellow has demonstrated sufficient competence
- 941 to enter practice without direct supervision.
- 942
- 943 V.B. Faculty Evaluation
- 944
- 945 V.B.1. At least annually, the program must evaluate faculty performance as
- 946 it relates to the educational program.
- 947
- 948 V.B.2. These evaluations should include a review of the faculty's clinical
- 949 teaching abilities, commitment to the educational program, clinical
- 950 knowledge, professionalism, and scholarly activities. These
- 951 evaluations must be confidential and must be reviewed with the
- 952 faculty members annually.
- 953
- 954 V.B.3. *Fellows must have the opportunity to provide confidential written*
- 955 *evaluations of each ~~teaching-attending-supervising~~ faculty member at the*
- 956 *end of a rotation.*
- 957
- 958 V.B.4. ~~be reviewed~~ *These evaluations must be reviewed with attending each*
- 959 *faculty member annually.*
- 960
- 961 V.C. Program Evaluation and Improvement
- 962
- 963 V.C.1. The program must document formal, systematic evaluation of the
- 964 curriculum at least annually. The program must monitor and track
- 965 each of the following areas:
- 966
- 967 V.C.1.a) fellow performance;
- 968
- 969 V.C.1.b) faculty development; and,

- 970
971 V.C.1.c) graduate performance, including performance of program
972 graduates on the certification examination.
973
974 V.C.1.c).(1) *At least 80% of program's graduating fellows from those*
975 *eligible to take an ABIM subspecialty certifying*
976 *examination upon completion of their training for the most*
977 *recently defined five year period who are eligible should*
978 *must have taken an the ABIM subspecialty certifying*
979 *examination. (Note: Five-year rolling pass rate for first time*
980 *takers of the ABIM certifying examination will be examined*
981 *at each program review).*
982
983 V.C.1.c).(2) *At least 80% of a program's graduates taking the ABIM*
984 *certifying examination for the first time during the most*
985 *recently defined five year period should pass.*
986
987 V.C.1.c).(3) *At least 80% of the entering fellows should have*
988 *completed the program when averaged over a five-year*
989 *period.*
990
991 **V.C.2.** **If deficiencies are found, the program should prepare a written plan**
992 **of action to document initiatives to improve performance in the**
993 **areas listed in section V.C.1. The action plan should be reviewed**
994 **and approved by the teaching faculty and documented in meeting**
995 **minutes.**
996
997 V.C.3. *Representative program personnel, at a minimum to include the program*
998 *director, representative faculty, and one fellow, must review program*
999 *goals and objectives, and the effectiveness with which they are achieved.*
1000
1001 **VI. Fellow Duty Hours in the Learning and Working Environment**
1002
1003 **VI.A. Professionalism, Personal Responsibility, and Patient Safety**
1004
1005 **VI.A.1. Programs and sponsoring institutions must educate fellows and**
1006 **faculty members concerning the professional responsibilities of**
1007 **physicians to appear for duty appropriately rested and fit to provide**
1008 **the services required by their patients.**
1009
1010 **VI.A.2. The program must be committed to and responsible for promoting**
1011 **patient safety and fellow well-being in a supportive educational**
1012 **environment.**
1013
1014 **VI.A.3. The program director must ensure that fellows are integrated and**
1015 **actively participate in interdisciplinary clinical quality improvement**
1016 **and patient safety programs.**
1017
1018 **VI.A.4. The learning objectives of the program must:**
1019
1020 **VI.A.4.a) be accomplished through an appropriate blend of supervised**

1021		patient care responsibilities, clinical teaching, and didactic
1022		educational events; and,
1023		
1024	VI.A.4.b)	not be compromised by excessive reliance on fellows to fulfill
1025		non-physician service obligations.
1026		
1027	<i>VI.A.1.a).(1)</i>	<i>Fellows' service responsibilities must be limited to patients</i>
1028		<i>for whom the teaching service has diagnostic and</i>
1029		<i>therapeutic responsibility.</i>
1030		
1031	VI.A.5.	The program director and sponsoring institution must ensure a
1032		culture of professionalism that supports patient safety and personal
1033		responsibility. Fellows and faculty members must demonstrate an
1034		understanding and acceptance of their personal role in the
1035		following:
1036		
1037	VI.A.5.a)	assurance of the safety and welfare of patients entrusted to
1038		their care;
1039		
1040	VI.A.5.b)	provision of patient- and family-centered care;
1041		
1042	VI.A.5.c)	assurance of their fitness for duty;
1043		
1044	VI.A.5.d)	management of their time before, during, and after clinical
1045		assignments;
1046		
1047	VI.A.5.e)	recognition of impairment, including illness and fatigue, in
1048		themselves and in their peers;
1049		
1050	VI.A.5.f)	attention to lifelong learning;
1051		
1052	VI.A.5.g)	the monitoring of their patient care performance improvement
1053		indicators; and,
1054		
1055	VI.A.5.h)	honest and accurate reporting of duty hours, patient
1056		outcomes, and clinical experience data.
1057		
1058	VI.A.6.	All fellows and faculty members must demonstrate responsiveness
1059		to patient needs that supersedes self-interest. Physicians must
1060		recognize that under certain circumstances, the best interests of the
1061		patient may be served by transitioning that patient's care to another
1062		qualified and rested provider.
1063		
1064	VI.B.	Transitions of Care
1065		
1066	VI.B.1.	Programs must design clinical assignments to minimize the number
1067		of transitions in patient care.
1068		
1069	VI.B.2.	Sponsoring institutions and programs must ensure and monitor
1070		effective, structured hand-over processes to facilitate both
1071		continuity of care and patient safety.

- 1072
1073 **VI.B.3.** Programs must ensure that fellows are competent in communicating
1074 with team members in the hand-over process.
1075
- 1076 **VI.B.4.** The sponsoring institution must ensure the availability of schedules
1077 that inform all members of the health care team of attending
1078 physicians and fellows currently responsible for each patient's care.
1079
- 1080 **VI.C.** Alertness Management/Fatigue Mitigation
1081
- 1082 **VI.C.1.** The program must:
1083
- 1084 **VI.C.1.a)** educate all faculty members and fellows to recognize the
1085 signs of fatigue and sleep deprivation;
1086
- 1087 **VI.C.1.b)** educate all faculty members and fellows in alertness
1088 management and fatigue mitigation processes; and,
1089
- 1090 **VI.C.1.c)** adopt fatigue mitigation processes to manage the potential
1091 negative effects of fatigue on patient care and learning, such
1092 as naps or back-up call schedules.
1093
- 1094 **VI.C.2.** Each program must have a process to ensure continuity of patient
1095 care in the event that a fellow may be unable to perform his/her
1096 patient care duties.
1097
- 1098 **VI.C.3.** The sponsoring institution must provide adequate sleep facilities
1099 and/or safe transportation options for fellows who may be too
1100 fatigued to safely return home.
1101
- 1102 **VI.D.** Supervision of Fellows
1103
- 1104 **VI.D.1.** In the clinical learning environment, each patient must have an
1105 identifiable, appropriately-credentialed and privileged attending
1106 physician (or licensed independent practitioner as approved by each
1107 Review Committee) who is ultimately responsible for that patient's
1108 care.
1109
- 1110 **VI.D.1.a)** This information should be available to fellows, faculty
1111 members, and patients.
1112
- 1113 **VI.D.1.b)** Fellows and faculty members should inform patients of their
1114 respective roles in each patient's care.
1115
- 1116 **VI.D.2.** The program must demonstrate that the appropriate level of
1117 supervision is in place for all fellows who care for patients.
1118
- 1119 Supervision may be exercised through a variety of methods. Some
1120 activities require the physical presence of the supervising faculty
1121 member. For many aspects of patient care, the supervising
1122 physician may be a more advanced fellow. Other portions of care

1123 provided by the fellow can be adequately supervised by the
1124 immediate availability of the supervising faculty member or fellow
1125 physician, either in the institution, or by means of telephonic and/or
1126 electronic modalities. In some circumstances, supervision may
1127 include post-hoc review of fellow-delivered care with feedback as to
1128 the appropriateness of that care.
1129

1130 **VI.D.3. Levels of Supervision**

1131
1132 To ensure oversight of fellow supervision and graded authority and
1133 responsibility, the program must use the following classification of
1134 supervision:
1135

1136 **VI.D.3.a) Direct Supervision – the supervising physician is physically**
1137 **present with the fellow and patient.**
1138

1139 **VI.D.3.b) Indirect Supervision:**
1140

1141 **VI.D.3.b).(1) with direct supervision immediately available – the**
1142 **supervising physician is physically within the hospital**
1143 **or other site of patient care, and is immediately**
1144 **available to provide Direct Supervision.**
1145

1146 **VI.D.3.b).(2) with direct supervision available – the supervising**
1147 **physician is not physically present within the hospital**
1148 **or other site of patient care, but is immediately**
1149 **available by means of telephonic and/or electronic**
1150 **modalities, and is available to provide Direct**
1151 **Supervision.**
1152

1153 **VI.D.3.c) Oversight – the supervising physician is available to provide**
1154 **review of procedures/encounters with feedback provided**
1155 **after care is delivered.**
1156

1157 **VI.D.4. The privilege of progressive authority and responsibility, conditional**
1158 **independence, and a supervisory role in patient care delegated to**
1159 **each fellow must be assigned by the program director and faculty**
1160 **members.**
1161

1162 **VI.D.4.a) The program director must evaluate each fellow’s abilities**
1163 **based on specific criteria. When available, evaluation should**
1164 **be guided by specific national standards-based criteria.**
1165

1166 **VI.D.4.b) Faculty members functioning as supervising physicians**
1167 **should delegate portions of care to fellows, based on the**
1168 **needs of the patient and the skills of the fellows.**
1169

1170 **VI.D.4.c) Fellows should serve in a supervisory role of residents or**
1171 **junior fellows in recognition of their progress toward**
1172 **independence, based on the needs of each patient and the**
1173 **skills of the individual fellow.**

1174		
1175	VI.D.5.	Programs must set guidelines for circumstances and events in
1176		which fellows must communicate with appropriate supervising
1177		faculty members, such as the transfer of a patient to an intensive
1178		care unit, or end-of-life decisions.
1179		
1180	VI.D.5.a)	Each fellow must know the limits of his/her scope of
1181		authority, and the circumstances under which he/she is
1182		permitted to act with conditional independence.
1183		
1184	VI.D.6.	Faculty supervision assignments should be of sufficient duration to
1185		assess the knowledge and skills of each fellow and delegate to
1186		him/her the appropriate level of patient care authority and
1187		responsibility.
1188		
1189	VI.E.	Clinical Responsibilities
1190		
1191		The clinical responsibilities for each fellow must be based on PGY-level,
1192		patient safety, fellow education, severity and complexity of patient
1193		illness/condition and available support services.
1194		
1195	VI.F.	Teamwork
1196		
1197		Fellows must care for patients in an environment that maximizes effective
1198		communication. This must include the opportunity to work as a member of
1199		effective interprofessional teams that are appropriate to the delivery of care
1200		in the specialty.
1201		
1202	VI.G.	Fellow Duty Hours
1203		
1204	VI.G.1.	Maximum Hours of Work per Week
1205		
1206		Duty hours must be limited to 80 hours per week, averaged over a
1207		four-week period, inclusive of all in-house call activities and all
1208		moonlighting.
1209		
1210	VI.G.1.a)	Duty Hour Exceptions
1211		
1212		A Review Committee may grant exceptions for up to 10% or a
1213		maximum of 88 hours to individual programs based on a
1214		sound educational rationale.
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1216		<i>The Review Committee for Internal Medicine will not consider</i>
1217		<i>requests for exceptions to the 80-hour limit to the fellows' work</i>
1218		<i>week.</i>
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1220	VI.G.1.a).(1)	In preparing a request for an exception the program
1221		director must follow the duty hour exception policy
1222		from the ACGME Manual on Policies and Procedures.
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1224	VI.G.1.a).(2)	Prior to submitting the request to the Review

Committee, the program director must obtain approval of the institution's GMEC and DIO.

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1228	VI.G.2.	Moonlighting
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1230	VI.G.2.a)	Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program.
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1234	VI.G.2.b)	Time spent by fellows in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.
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1238	VI.G.3.	Mandatory Time Free of Duty
1239		
1240		Fellows must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.
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1244	VI.G.4.	Maximum Duty Period Length
1245		
1246		Duty periods of fellows may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.
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1253	VI.G.4.a)	It is essential for patient safety and fellow education that effective transitions in care occur. Fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
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1259	VI.G.4.b)	Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
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1262	VI.G.4.c)	In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.
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1270	VI.G.4.c).(1)	Under those circumstances, the fellow must:
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1272	VI.G.4.c).(1).(a)	appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
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1276	VI.G.4.c).(1).(b)	document the reasons for remaining to care for
1277		the patient in question and submit that
1278		documentation in every circumstance to the
1279		program director.
1280		
1281	VI.G.4.c).(2)	The program director must review each submission of
1282		additional service, and track both individual fellow and
1283		program-wide episodes of additional duty.
1284		
1285	VI.G.5.	Minimum Time Off between Scheduled Duty Periods
1286		
1287	VI.G.5.a)	Fellows must be prepared to enter the unsupervised practice
1288		of medicine and care for patients over irregular or extended
1289		periods.
1290		
1291		<i><u>Internal medicine subspecialty fellows are considered to be in the</u></i>
1292		<i><u>final years of education.</u></i>
1293		
1294	VI.G.5.a).(1)	This preparation must occur within the context of the
1295		80-hour, maximum duty period length, and one-day-
1296		off-in-seven standards. While it is desirable that
1297		fellows have eight hours free of duty between
1298		scheduled duty periods, there may be circumstances
1299		when these fellows must stay on duty to care for their
1300		patients or return to the hospital with fewer than eight
1301		hours free of duty.
1302		
1303	VI.G.5.a).(1).(a)	Circumstances of return-to-hospital activities
1304		with fewer than eight hours away from the
1305		hospital by fellows must be monitored by the
1306		program director.
1307		
1308	VI.G.5.a).(1).(b)	<i><u>In unusual circumstances, fellows may remain</u></i>
1309		<i><u>beyond their scheduled period of duty or return</u></i>
1310		<i><u>after their scheduled period of duty to provide care</u></i>
1311		<i><u>to a single patient. Justifications for such</u></i>
1312		<i><u>extensions of duty are limited to reasons of</u></i>
1313		<i><u>required continuity of care for a severely ill or</u></i>
1314		<i><u>unstable patient, academic importance of the</u></i>
1315		<i><u>events transpiring, or humanistic attention to the</u></i>
1316		<i><u>needs of the patient or family. Such episodes</u></i>
1317		<i><u>should be rare, must be of the fellows' own</u></i>
1318		<i><u>initiative, and need not initiate a new 'off-duty</u></i>
1319		<i><u>period' nor require a change in the scheduled 'off-</u></i>
1320		<i><u>duty period.'</u></i>
1321		
1322	VI.G.5.a).(1).(c)	<i><u>Under such circumstances, the fellow must</u></i>
1323		<i><u>appropriately hand over care of all other patients to</u></i>
1324		<i><u>the team responsible for their continuing care, and</u></i>
1325		<i><u>document the reasons for remaining or returning to</u></i>
1326		<i><u>care for the patient in question and submit that</u></i>

1327 *documentation to the program director.*

1328

1329 VI.G.5.a).(1).(d) *The program director must review each submission*

1330 *of additional service and track both individual*

1331 *fellows' and program-wide episodes of additional*

1332 *duty.*

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1334 **VI.G.6. Maximum Frequency of In-House Night Float**

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1336 **Fellows must not be scheduled for more than six consecutive nights**

1337 **of night float.**

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1339 **VI.G.7. Maximum In-House On-Call Frequency**

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1341 **Fellows must be scheduled for in-house call no more frequently than**

1342 **every-third-night (when averaged over a four-week period).**

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1344 VI.G.7.a) *Internal Medicine residency programs are fellowships must not*

1345 *allowed to average in-house call over a four-week period.*

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1347 **VI.G.8. At-Home Call**

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1349 **VI.G.8.a) Time spent in the hospital by fellows on at-home call must**

1350 **count towards the 80-hour maximum weekly hour limit. The**

1351 **frequency of at-home call is not subject to the every-third-**

1352 **night limitation, but must satisfy the requirement for one-day-**

1353 **in-seven free of duty, when averaged over four weeks.**

1354

1355 **VI.G.8.a).(1) At-home call must not be so frequent or taxing as to**

1356 **preclude rest or reasonable personal time for each**

1357 **fellow.**

1358

1359 **VI.G.8.b) Fellows are permitted to return to the hospital while on at-**

1360 **home call to care for new or established patients. Each**

1361 **episode of this type of care, while it must be included in the**

1362 **80-hour weekly maximum, will not initiate a new "off-duty**

1363 **period".**

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